

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00001

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 701 ARUNDEL ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MR. EMMETT W. ABELL

3. (b) Social Security Number

235-32-6922

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEMARRIED6. (b) Name of husband or wife BESSIE J. BOUCHER

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 31, 18958. AGE: Years Months Days If less than one day
50 4 28 hrs. min.9. Birthplace W. VA.
(Town, county, and state)10. Usual occupation CONTRACTOR

11. Industry or business

12. Name LEMUEL ABELL13. Birthplace WEST VIRGINIA14. Maiden name ELIZABETH WHITACRE15. Birthplace WEST VIRGINIA16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof Feb. 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Maryland18. Funeral director William H. KightAddress Cumberland, Maryland19. Jan. 31, 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 29, 1946 at 5:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 25, 1946 to JAN. 29, 1946and that I last saw him alive on JAN. 29, 1946

Immediate cause of death

DURATION

Chronic Myocarditis

Due to

Due to

Other conditions

Myocardial infarction
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Med. Bldg. Supt. Date signed 1/31/46

MARGIN RESERVED FOR BINDING

VS A15

9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 5 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits. DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

00002

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMPERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMPERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 S. LEE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

ANDERSON, GEORGE W. MR.

3.(b) Social Security Number

214-07-0773

4. Sex <u>MALE</u>	5. Color or race <u>WHITE</u>	6.(a) Single, married, widowed, or divorced <u>MARRIED</u>
6.(b) Name of husband or wife <u>ROSE, MARGARET</u>		
6.(c) If alive, give age <u>59</u> years		
7. Birth date of deceased (mo., day, yr.) <u>February 24, 1880</u>		
8. AGE: Years <u>65</u>	Months <u>11</u>	Days <u>4</u>
If less than one day hrs. min.		

9. Birthplace MD.
(Town, county, and state)
10. Usual occupation POLICE @ KELLY TIRE CO.
11. Industry or business

FATHER	12. Name <u>ANDERSON, THOMAS</u>
	13. Birthplace <u>MD.</u>
MOTHER	14. Maiden name <u>PLUMMER, MARY</u>
	15. Birthplace <u>MD.</u>

16. Informant Mrs. Mary Jane Tyree
Address La Vale, Md.
17. Burial Date thereof Jan 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md.

18. Funeral director John J. Hefner
Address Cumberland, Md.
19. Jan 31, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 28, 1946, 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-12- 1946 to 1-28- 1946
and that I last saw him alive on 1-28- 1946

Immediate cause of death arteriosclerosis with coronary sclerosis
DURATION

Due to.....
Due to.....
Other conditions Benzophenone prostatic
(Include pregnancy within 3 months of death)

Major findings of operations Benzophenone prostatic
Date of op. 1-19-46
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?
23. SIGNATURE Howard J. Tolson
Address Cumberland, Md. Date signed 1-28-46

RECEIVED
FEB 5 1946
BUREAU OF

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Floyd T. Arnold

3. (b) Social Security Number

213-18-2367

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Cooper

7. Birth date of

deceased (mo., day, yr.)

April 18, 1897

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4896hrs.min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

Greenhouse

FATHER

12. Name

Silas Arnold

13. Birthplace

Maryland

14. Maiden name

Chetta Summers

15. Birthplace

Maryland

16. Informant

Memorial Hospital

Address

Pittsburgh, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

Jan 21, 1946
(month) (day) (year)

Cemetery or crematory

Andrews Cem

Location

Oakland, Md.

18. Funeral director

Emory Bolden

Address

Oakland, Md.

19.

(Date rec'd by registrar)

Jan 24, 1946 J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 181946, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 17 1946 to Jan 18 1946and that I last saw him alive on Jan 19 1946

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. B. Washburn, Jr.

M. D. or other

Address

49 Greene StDate signed 1-20-46

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

ADDRESS OF REGISTRAR

CITY OF REGISTRAR

STATE OF REGISTRAR

COUNTY OF REGISTRAR

TOWN OF REGISTRAR

WARD OF REGISTRAR

PREVIOUS RESIDENCE

DATE OF PREVIOUS RESIDENCE

PLACE OF PREVIOUS RESIDENCE

NAME OF PREVIOUS REGISTRAR

DATE OF PREVIOUS REGISTRATION

PLACE OF PREVIOUS REGISTRATION

NAME OF PREVIOUS REGISTRAR

ADDRESS OF PREVIOUS REGISTRAR

CITY OF PREVIOUS REGISTRAR

STATE OF PREVIOUS REGISTRAR

COUNTY OF PREVIOUS REGISTRAR

TOWN OF PREVIOUS REGISTRAR

WARD OF PREVIOUS REGISTRAR

PREVIOUS RESIDENCE

DATE OF PREVIOUS RESIDENCE

PLACE OF PREVIOUS RESIDENCE

NAME OF PREVIOUS REGISTRAR

DATE OF PREVIOUS REGISTRATION

PLACE OF PREVIOUS REGISTRATION

NAME OF PREVIOUS REGISTRAR

ADDRESS OF PREVIOUS REGISTRAR

CITY OF PREVIOUS REGISTRAR

STATE OF PREVIOUS REGISTRAR

COUNTY OF PREVIOUS REGISTRAR

TOWN OF PREVIOUS REGISTRAR

WARD OF PREVIOUS REGISTRAR

PREVIOUS RESIDENCE

DATE OF PREVIOUS RESIDENCE

PLACE OF PREVIOUS RESIDENCE

NAME OF PREVIOUS REGISTRAR

DATE OF PREVIOUS REGISTRATION

PLACE OF PREVIOUS REGISTRATION

NAME OF PREVIOUS REGISTRAR

ADDRESS OF PREVIOUS REGISTRAR

CITY OF PREVIOUS REGISTRAR

STATE OF PREVIOUS REGISTRAR

COUNTY OF PREVIOUS REGISTRAR

TOWN OF PREVIOUS REGISTRAR

WARD OF PREVIOUS REGISTRAR

RECEIVED

JAN 30 1946

BUREAU U.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

00004
Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Chimberland 2nd
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
144 Wincow St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Allegany
City or town Chimberland 2nd
(If outside city or town limits, write RURAL and give nearest town)
Street No. 144 Wincow St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Walter Banks

3.(b) Social Security Number

None

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife 3rd Polo
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 2 1877
8. AGE: Years 68 Months 6 Days 23 If less than one day _____ hrs. _____ min.
9. Birthplace Romney W. Va.
(Town, county, and state)
10. Usual occupation Janitor (Retired)
11. Industry or business Old jobs
12. Name Daniel Banks
13. Birthplace W. Va.
14. Maiden name Ann Unknown
15. Birthplace

16. Informant Gertrude Banks
Address 144 Wincow St. Chimberland 2nd
17. Burial (Burial, cremation, or removal) Which? Date thereof Jan 30 46
(month) (day) (year)
Cemetery or crematory Summer Cnd
Location Chimberland
18. Funeral director Louis Stein Inc
Address Chimberland md
19. Jan 30 19 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946 at 12:30 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
and that I last saw him _____ alive on _____ 19 _____
Immediate cause of death Coronary Thrombosis DURATION _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____

Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Primer H. Gerson M.D. M. D. or other _____
Address Chimberland md Date signed 1-25-46
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 5 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 min
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 25 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Baby boy Bean

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Infant
6.(b) Name of husband or wife - B.(c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) January 2, 1946
8. AGE: Years 0 Months 0 Days 0 If less than one day 25 hrs. min.

9. Birthplace Frostburg, Allegany, Md
(Town, county, and state)
10. Usual occupation

11. Industry or business

12. Name Charles O Bean
13. Birthplace Frostburg, Md
14. Maiden name Dalores J. Keifer
15. Birthplace Arlington, Va.

16. Informant Mrs. Dalores Keifer Bean
Address Frostburg, Md.

17. Burial, cremation, or removal, Where? Burial Date thereof 1-3-1946
(month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.

19. Funeral director James H. Keifer
Address Frostburg, Md.

19. 1-3 46 Mrs. Nancy H. Ke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 19 46 at 10:15 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 46 to Jan 2 19 46
and that I last saw him alive on Jan 2 19 46

Immediate cause of death Congenital Hydrocephalus
Spina Bifida
Due to

Due to
Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work

23. SIGNATURE Wm Mc Lane MD
M. D. or other
Address Frostburg, Md Date signed 1-3-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 000069

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
38 W. Cullough St.
 How long in hospital or institution? MC Cullough

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 38 - W. Cullough St.
 (If rural, give L.O.C. & dist.)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jessie Beeman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Noah J. Beeman
 7. Birth date of deceased (mo., day, yr.) May 25, 1880 8.(c) If alive, give age 70 years
 8. AGE: Years 65 Months 8 Days 2 If less than one day
 hrs. min.

9. Birthplace Pennsylvania
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business Own home

FATHER 12. Name George Bennett

13. Birthplace Flinstone, Md.

MOTHER 14. Maiden name Jessie Nickel

15. Birthplace Scotland

16. Informant Noah Beeman, Sr.

Address Frostburg, Md.

17. Burial Date thereof Jan 30, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. 1-29 19 46 Dus. Nancy H. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1946 at 105 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1943 to Jan 27, 1946 and that I last saw him alive on January 27, 1946

Immediate cause of death Cardio-Vascular renal disease with hypertension DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Gattens M.D. M. D. or other

Address Frostburg, Md. Date signed 1/28/46

RECEIVED

JAN 31 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00007

Reg. Dist. No. 2

1. PLACE OF DEATH
County... Allegheny
City or town... Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... W. Va. County... Morgan
City or town... Morgantown
(If outside city or town limits, write RURAL and give nearest town)
Street No... 904 Cornell Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME
Margie J. Belfiore

3. (b) Social Security Number

4. Sex F 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Hugo Belfiore
7. Birth date of deceased (mo., day, yr.) Feb. 6, 1903 8. (c) If alive, give age 42 years
8. AGE: Years 42 Months 11 Days 5 If less than one day
hrs. min.

9. Birthplace Westernport, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
12. Name John W. Wharton
13. Birthplace Maryland
14. Maiden name Harriet Kifer
15. Birthplace Maryland

16. Informant Hugo Belfiore
Address 904 Cornell Ave. Morgantown W. Va.
17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan. 14, 1946
(month) (day) (year)
Cemetery or crematory Glendale Cemetery
Location Near Kifer, Maryland
18. Funeral director Louis Stein, Inc.
Address Cumberland Md.
19. Jan 12 19 46 Nina L. Bender
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1946 at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10, 1946 to Jan. 11, 1946
and that I last saw her alive on Jan. 10, 1946

Immediate cause of death Tuberculosis of lungs
DURATION Do not know
Due to
Due to
Other conditions

(Include pregnancy within 8 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. A. Watson M.D.
Address Little Orleans, Md. Date signed 1/12/46
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2000 BY 60322 UCBAW

RECEIVED
JAN 16 1946
BUREAU V.B.

POSTAL SERVICE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

00008

CERTIFICATE OF DEATH

Reg. Diat. No. *4*

1. PLACE OF DEATH:

County *Allegany*

City or town *Cumberland*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

321 Pennsylvania Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State *Maryland* County *Allegany*

City or town *Cumberland*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *321 Pennsylvania Ave.*
(If rural, give LOCATION)

2. (a) If veteran, name war *_____*

3. (a) FULL NAME

Robert Allen Boggs

3. (b) Social Security Number

None

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *October 28, 1944*

8. AGE: Years *1* Months *2* Days *6* If less than one day _____ hrs. _____ min.

9. Birthplace *Cumberland Md.*
(Town, county, and state)

10. Usual occupation *Infant*

11. Industry or business

12. Name *Herman Boggs*

13. Birthplace *Oldtown, Md.*

14. Maiden name *Rosella M. Hull*

15. Birthplace *Martins Ferry, Ohio*

16. Informant *Herman Boggs*

Address *Cumberland, Md.*

17. *Burial* Date thereof *January 7, 1946*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Mt. Olivet Methodist Cemetery*

Location *near Oldtown, Md.*

18. Funeral director *John J. Hoff*

Address *Cumberland, Md.*

19. *Jan 7, 1946* *Joe C. Franklin*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *January 4, 1946* at *3:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 30, 1945* to *Jan 4, 1946*

and that I last saw him alive on *Jan 4, 1946*

Immediate cause of death

Pneumonia

DURATION

2 days

Influenza

7 days

Due to *Influenza*

Due to *_____*

Other conditions *_____*

(Include pregnancy within 3 months of death)

Major findings of operations

Dates of op. *_____*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Dates of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE *W. S. Owens*

M. D. or other

Address *13350 Ave* Date signed *1/7/46*

RECEIVED

JAN 15 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 336

CERTIFICATE OF DEATH

00009

Reg. Dist. No. 9

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 24 1946

to

Jan 24 1946

and that I last saw him alive on

Jan 24 1946

Immediate cause of death

Heart Block

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED
JAN 29 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 446

00010

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

1211 E. Oldtown Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Alleg.

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1211 E. Oldtown Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Frederick Marshall Brinkman

3.(b) Social Security Number

705-12-2045

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Mary O. Kunsman

7. Birth date of

deceased (mo., day, yr.)

May 16th, 1898

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

47

7

28

hrs.

min.

9. Birthplace Little Orleans, Md.

(Town, county, and state)

10. Usual occupation Steel Worker

11. Industry or business Construction Co.

12. Name Marshall Brinkman

13. Birthplace Md.

14. Maiden name Margaret Linaburg

15. Birthplace Md.

16. Informant Mrs. Mary O. Brinkman

Address Cumberland, Md.

17. Burial Date thereof Jan. 16 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Jan. 15, 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1946 at 9 9: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 46 to Jan 14 46
and that I last saw him alive on Jan 14 1946

Immediate cause of death

Hodgkins disease

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

MSB Owens M.D.
133 Va ave.
Address Date signed 1/14/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

00011

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
527. Louisiana Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 527. Louisiana Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary LeTreacha Brown
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

3. (b) Social Security Number

None

6. (b) Name of husband or wife Robert Brown
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 12 1860
 8. AGE: Years 85 Months 10 Days 29 If less than one day hrs. min.

9. Birthplace Winchester, Virginia
 (Town, county, and state)

10. Usual occupation House Duty

11. Industry or business Own House

FATHER 12. Name Joseph Brown

13. Birthplace Winchester, Va.

MOTHER 14. Maiden name Sarah Smith

15. Birthplace Winchester, Va.

16. Informant Fred M. Brown

Address 727. Gephart Drive, Cumberland, Md

17. Burial Date thereof 1/15/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rosedale Cemetery

Location Martinsburg, W. Va.

18. Funeral director William H. Knight

Address Cumberland, Md.

19. Jan 15 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 19 46 at 11-20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 45 to Jan 11 46

and that I last saw her alive on Sept. 11 46

Immediate cause of death Generalized arteriosclerosis DURATION 10 yrs

Due to Phaemia 6 wks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph L. Franklin

M. D. or other 1-12-46
 Address 245 Va. Ave. Date signed

RECEIVED

JAN 15 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33d)

CERTIFICATE OF DEATH

00012

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Maudie Elizabeth Carr

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Thomas Carr

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 18768. AGE: Years Months Days If less than one day
69 2 12 hrs. min.9. Birthplace Pendleton Co., W. Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Amos Bennett13. Birthplace Riverton, W. Va.14. Maiden name Nancy Elizabeth Bennett15. Birthplace Riverton, W. Va.16. Informant Margie L. KettermanAddress Rawlings, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-16-46
(month) (day) (year)Cemetery or crematory Waxler CemeteryLocation Rawlings, Md.18. Funeral director N. L. Rogers Funeral DirectorsAddress Keyser, W. Va.19. Jan 16 19 46 Waxler
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14th. 19 46, at21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Jan 14 19 46 and that I last saw her alive on Jan 13 19 46Immediate cause of death Ch. Myocardial DURATION 7Due to old age - heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. L. Rogers M. D. or otherAddress Waxler MD Date signed 1/15/46

RECEIVED

JAN 19 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

CERTIFICATE OF DEATH

00013

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 98 Park Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sorathy Inez Davis Carter

3. (b) Social Security Number

4. Sex Female

5. Color or race colored

6.(a) Single, married, widowed, or divorced unmarried

6.(b) Name of husband or wife Leroy C. Carter

6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) May 17th, 1921

8. AGE: Years 24 Months 7 Days 22 If less than one day

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Simon Davis

13. Birthplace Pittsburgh, Pa.

14. Maiden name Georgia Moore

15. Birthplace Pittsburgh, Pa.

16. Informant Leroy C. Carter

Address 98 Park Ave. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 13, 1946
(month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Maryland

18. Funeral director Jacob Hall

Address Frostburg, Maryland

19. 1-11 19 46 Mr. Harry A. De
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1946 at 6:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 31, 1945 to Jan. 9, 1946

and that I last saw him alive on January 9, 1946

Immediate cause of death Pulmonary Embolism

Due to Appendicitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations acute appendicitis

Date of op. 12-31-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. Stahl, M.D.
Address Frostburg, Md. Date signed 1-11-46

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

00014

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 74 yrs.

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 145 Thomas St.

(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

John Joseph Clarke

3. (b) Social Security Number

716-22-5392

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Andrea S. Saille

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 28 18718. AGE: Years Months Days If less than one day
74 1 9 _____ hrs. _____ min.9. Birthplace Cumberland Ind.
(Town, county, and state)10. Usual occupation Helper Bakery

11. Industry or business

12. Name Philip G. Clarke13. Birthplace Island14. Maiden name Catherine Shannon15. Birthplace Ind.16. Informant John J. Clarke Jr.Address Cumberland17. Burial Date thereof 1-12-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Patrick's Conv.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. Jan. 11, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH January 9th, 1946 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION
Crushed left chest; possible skull fracture, temporal region; 2 hrs., 50 min.

Due to _____

Due to _____

Other conditions Comminuted fractures both bones, both legs, lac. left lung, subcutaneous emphysema.
(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-8-46Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) streetMeans of injury struck by auto Injured at work? no23. SIGNATURE James H. Bowman, M.D.
M. D. or otherAddress Cumberland, Maryland Date signed 1-10-46Deputy Medical Examiner: Allegany Co.

RECEIVED

JAN 15 1946

BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

00015

Reg. Diat. No. 9

1. PLACE OF DEATH:

County allegany

City or town Northampton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles W. Clise

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Anna Clise

7. Birth date of deceased (mo., day, yr.)

March 30 - 1871

8. AGE:

74 Years

9 Months

2 Days

If less than one day

hrs. min.

9. Birthplace

Sanmit alleg - md
(Town, county, and state)

10. Usual occupation

invalid

11. Industry or business

FATHER

12. Name

George Clise

13. Birthplace

md.

MOTHER

14. Maiden name

Lavina Wintem

15. Birthplace

md.

16. Informant

Mrs Stanley Banc

Address

Lavale, md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 4 - 1946
(month) (day) (year)

Cemetery or crematory

allegany

Location

Northampton, md.

18. Funeral director

Address

J. J. Clise
Northampton md

19. 1-3

(Date rec'd by registrar)

46 Mrs. Nancy H. Banc
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md.

County

allegany

City or town

Cumberland R.D. #1
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Red Hill

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 1

19. 46

at 2:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 31

19. 45

to Jan 1

19. 46

and that I last saw him alive on Dec 31

19. 45

Immediate cause of death

arterio sclerosis

DURATION

several years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. M. Lane

M. D. or other

Address

Northampton md

Date signed

1-2-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 7 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00016

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 77 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wd. County AlleganyCity or town Barton, Wd.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Edward Peter Comer

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteSingle

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 18688. AGE: Years 77 Months 11 Days 22 If less than one day
..... hrs. min.9. Birthplace Barton-Allegany- Md.
(Town, county, and state)10. Usual occupation Miner11. Industry or business Coal Miner.12. Name Edward Comer13. Birthplace Ireland14. Maiden name Bridgett Connors15. Birthplace Virginia16. Informant Agnes ComerAddress Barton, Md.17. Burial Date thereof Jan 28-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Gabriels Cem.Location Barton, Md.18. Funeral director Ellsworth S. BoalAddress Westernport, Md.19. Jan 26 1946 W. C. Babin Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24, 1946, at 7a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 20 1946 to Jan 24 1946
and that I last saw him alive on Jan 20 1946Immediate cause of death Pneumo-pneumonia DURATION 2 day.Due to Influenza 4 day.Due to Pneumonia 4 day.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norman Reeves M.D. M. D. or otherAddress Westernport, Md Date signed 1-26-46

RECEIVED
JAN 28 1946
BUREAU V.E.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

19 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... PENNSYLVANIA County... SOMERSETCity or town... GLENCOE
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

GEORGE H. COOK

3. (b) Social Security Number

705-09-5900

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED6.(b) Name of husband or wife... ANNA HARSH COOK

6.(c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.) APR. 25, 1871

8. AGE:

Years

Months

Days

If less than one day

7491

hrs.

min.

9. Birthplace

PENNA

(Town, county, and state)

10. Usual occupation

RETIRED RAILROADER

11. Industry or business

FATHER

12. Name

JESSIE COOK

13. Birthplace

PA.

MOTHER

14. Maiden name

ADELINE SHROCK

15. Birthplace

Unknown

16. Informant

Harry Cook

Address

Glencoe Pa.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Jan 29 1946
(month) (day) (year)

Cemetery or crematory

Glencoe Pa.

Location

Mt Lebanon Ceme.

18. Funeral director

Johnson & Son

Address

Berlin Pa.

19.

(Date rec'd by registrar)

Jan 28 1946J. C. Franklin
M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... JAN. 26... 1946 at 2:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-7-1946to 1-26-1946and that I last saw him alive on 1-26-1946

Immediate cause of death

DURATION

Arteriosclerosis
myocardial degeneration

Due to

Due to

Other conditions

Chronic nephritis
Benign hypertrophy prostate
(Indicate pregnancy within 3 months of death)

Major findings of operations

no operation

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

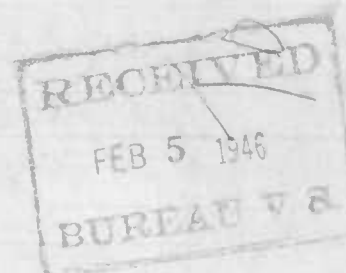
Injured at home, farm, industry, public place (where?)

Means of injury

Injured by work?

23. SIGNATURE

Howard R. Polson M.D.
Cumberland, Md. Date signed 1-27-46



W.S.

for

Johnson, Berlin

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-d)

CERTIFICATE OF DEATH

00018

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Allegany Co Infirmary
How long in hospital or institution?

3. (a) FULL NAME

William Davidson

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Sept. 6 1867

B. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78413

hrs.

min.

9. Birthplace

Pa.
(Town, county, and state)

10. Usual occupation

11. Industry or business

None

FATHER

12. Name

John Davidson

13. Birthplace

Pa.

MOTHER

14. Maiden name

Alice Hess

15. Birthplace

Pa.

16. Informant

Supr Alleg Co Infirmary

Address

Cumtland Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

St Patrick's Cem

Location

Mr Savage Md

18. Funeral director

Louis Steen

Address

Cumtland Md

19.

(Date rec'd by registrar)

Jan. 19 1946 J. L. Franklin M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County allegCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)Street No. Mr Savage md
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH 1-19-1946 at 4:40 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21 1931 to 1-19-1946and that I last saw him/her on 1-17-1946

Immediate cause of death

Status AsthmaticusChronic myocardialDegeneration

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

NoneDate of op. none

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. F. Williams

M. D. or other

Address Cumtland Date signed 1-19-46

July 21-1931

RECEIVED
JAN 22 1946
BUREAU 16

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

00019 4

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
125 Bedford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 222 N. Centre St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Richard Davis

3.(b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married?</u>
B.(b) Name of husband or wife <u>Ida Tigner</u>		
6.(c) If alive, give age years		
7. Birth date of deceased (mo., day, yr.) <u>1860 ?</u>		
8. AGE: Years <u>85.?</u>	Months	Days
If less than one day hrs. min.		
9. Birthplace <u>va</u> (Town, county, and state)		
10. Usual occupation <u>farmer</u>		
11. Industry or business <u>odd jobs</u>		
FATHER	12. Name <u>Unknown</u>	
MOTHER	13. Birthplace <u>Unknown</u>	
14. Maiden name		
15. Birthplace		

16. Informant <u>Brascelino Parker</u>		
Address <u>418 N. Centre St. Cumberland</u>		
17. <u>Burial</u>	Date thereof <u>Jan 30 46</u> (month) (day) (year)	
Cemetery or crematory <u>Summer Cms.</u>		
Location <u>Cumberland Ind.</u>		
18. Funeral director <u>Louis Stein Inc.</u>		
Address <u>Cumberland</u>		
19. <u>Jan 30 46</u>	J.P. Haukley, M.D. Registrar	
(Date rec'd by registrar)		

MEDICAL CERTIFICATION

20. DATE OF DEATH <u>January 26th</u> , 19 <u>46</u> at <u>11:22 P.M.</u>
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19....., to 19..... and that I last saw h..... alive on 19..... Immediate cause of death <u>Coronary Occlusion</u> DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations.....
Antopsy results <u>no autopsy</u>
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE <u>Richard H. Bourey, M.D.</u> M. D. or other Address <u>Cumberland, Maryland</u> Date signed <u>1-29-46</u> Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 5 1946
BUREAU V B

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MARYLAND County... ALLEGANY
City or town... ELK LUTHERSTONE
(If outside city or town limits, write RURAL and give nearest town)
Street No... ROUTE #1
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

DeWAYNE DICKEN

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife
6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) AUG. 12, 1935

8. AGE: Years 10 Months 4 Days 28 It less than one day hrs. min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation STUDENT

11. Industry or business

12. Name WILBUR DICKEN

13. Birthplace PENNA.

14. Maiden name BEULAH RADCLIFFE

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Jan. 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prosperity Cemetery

Location Everett, Pa.

18. Funeral director Ross, Balentine

Address Everett, Pa.

19. Jan. 5 1946 Joseph R. Zankle M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH JAN. 4, 1946 at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1:15 PM, 1945, to JAN. 4, 1946, and that I last saw him alive on Jan 3rd, 1946.

Immediate cause of death

DURATION

Due to Pneumococcus meningitis 3 wks

Due to Brain abscess 1 day

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Owens M. D. or other

Address Everett, Pa. Date signed 1-4-46

RECEIVED
JAN 8 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17003

00021

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 301 Harrison St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Martin Statwood Duncan

3. (b) Social Security Number

705-05-46254. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced6.(b) Name of husband or wife Delena Royce Duncan7. Birth date of deceased (mo., day, yr.) December 6, 1895 6.(c) If alive, give age 45 years8. AGE: Years 50 Months 1 Days 10 If less than one day
..... hrs. min.9. Birthplace Luray, Virginia
(Town, county, and state)10. Usual occupation Blacksmith11. Industry or business B&O RR12. Name John W. Duncan13. Birthplace Virginia14. Maiden name Wentworth

15. Birthplace

16. Informant Mrs. Delena R. DuncanAddress Cumberland, Md.17. Burial Date thereof January 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director John J. HogueAddress Cumberland, Md.19. Jan. 18, 46 J.P. Haukley, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH January 16th., 1946 at 1.10 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Fractured skull at base;
" right temporal bone.

DURATION

10 days19 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

under investigation Date of 1-5-46

Accident, suicide, or homicide

Where did injury occur? near Cresaptown, Allegany, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highwayMeans of injury struck by auto Injured at work? no23. SIGNATURE James H. Bonou M.D.

M. D. or other

Address Cumberland, Maryland Date signed 1-17-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1946

BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

00022

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? Ten days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 Laing Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Mrs. Mary Earson Clara Mary E. Earson
3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Deceased
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Mar., 1900 Nov 22, 1901
8. AGE: Years 44 Months 1 Days 15 It less than one day _____ hrs. _____ min.
9. Birthplace Corriganville, Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home

FATHER
12. Name Deceased Arman D. Martin
13. Birthplace Corriganville, Md
MOTHER
14. Maiden name Deceased Nora A. Davidson
15. Birthplace Marietta, Ohio

16. Informant Robert A. Martin
Address Mt. Savage, Md
17. Burial Date thereof Jan 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Savage Methodist
Location Mt. Savage, Md.

18. Funeral director Thy J. Hofer
Address Cumberland, Md.
19. Jan. 10, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH January 7 19 46 at 1: P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____
and that I last saw him _____ alive on _____ 19 _____
Immediate cause of death Myocarditis with
Dissection DURATION 10 days
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE James T. Johnson M. D. or other _____
Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

I

VS A15 9.45 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATION OF THE UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

RECEIVED

JAN 15 1945

BUREAU

ADDITIONAL COPIES

FOR CONSENT

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 Years
Hospital, institution, or street address where death occurred:
309, Bedford St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 309, Bedford St
(If rural, give LOCATION)
2(a) If veteran, name war

3.(a) FULL NAME
Marian Grace Eyler

3.(b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16 1905

8. AGE: Years 40 Months 2 Days 19 It less than one day hrs. min.

9. Birthplace Lonaconing, Allegheny Co, Maryland
(Town, county, and state)

10. Usual occupation School Teacher

11. Industry or business Public School

12. Name George D. Eyler

13. Birthplace Hazen, Pa

14. Maiden name Lucy Issac

15. Birthplace Cumberland, Md.

16. Informant Mrs. Lucy Eyler

Address 309, Bedford St, Cumberland, Md.

17. Burial Date thereof 1/12/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Jan 10, 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about
20. DATE OF DEATH January 5th, 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19..... to19.....
and that I last saw h.....alive on19.....

Immediate cause of death Coronary Occlusion

Due to

Due to

Other conditions (body discovered by family in an attic room this evening-8.30P.M.
(Include pregnancy within 3 months of death)
January 9th.,46)

Major findings of operations

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Boyson, M.D.
M. D. or other
Cumberland, Maryland Date signed 1-9-46
Address

Deputy Medical Examiner - Allegheny Co

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 15 1946
BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? two days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Franklin T. Fink

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 23, 1945

8. AGE: Years Months Days If less than one day

5 mos. 5 10 _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business _____

12. Name Luther Fink13. Birthplace Va.14. Maiden name Delphie Browers15. Birthplace W. Va.16. Informant Luther FinkAddress Rawlings, Maryland17. Burial Date thereof Feb. 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Waxler CemeteryLocation Rawlings Maryland18. Funeral director William H. KightAddress Cumberland, Maryland19. Feb. 2 19 46 Joseph P. Dablin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 19 46 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 29 19 46 to January 31 19 46and that I last saw him alive on January 31 19 46

Immediate cause of death _____

pneumoniaDURATION 3 daysDue to pneumonia

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operation _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. Dablin M.D.Address Rawlings Date signed 1-31-46

MARGIN RESERVED FOR BINDING

9.45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 5 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County AlleganyCity or town Mt Savage
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph Edward Finzel

3. (b) Social Security Number

215-10-12864. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Lillie Weisenborn6.(c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) January 15 18828. AGE: Years 64 Months 0 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace Mt Savage Allegany Co. Md
(Town, county, and state)10. Usual occupation Miss Supt

11. Industry or business _____

12. Name Edward Finzel13. Birthplace Finzel Md14. Maiden name Harriett Jenkins15. Birthplace Mt Savage Md16. Informant Mrs Lillie FinzelAddress Mt Savage Md17. Burial Date thereof 1-25-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg Md18. Funeral director Jacob J. HafnerAddress Frostburg Md19. 1/22 - 46 Veronica M. Wernick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22nd 1946 at 1:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 45 to January 21st 1946and that I last saw him alive on January 21st 1946Immediate cause of death Cerebral Thrombosis -Aortic Regurgitation

Due to _____

Due to _____

Other conditions Chronic Nephritis.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

23. SIGNATURE William E. Mosley M.D. M. D., or other _____Address Mt Savage Md. Date signed 1-22-1946

RECEIVED TO THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

CERTIFICATE OF DEATH

RECEIVED

FEB 3 1946

BUREAU

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00026

Reg. Dist. No. 5

1. PLACE OF DEATH:

County AlleganyCity or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

The Miller Hwy Rt 220

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)Street No. The Miller Hwy Rt 220
(If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

William Hess Flanagan

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Rebecca J. Simmons

7. Birth date of deceased (mo., day, yr.)

May 14 1867

8. AGE:

Years 78 Months 8 Days 15 Less than one day _____ hrs. _____ min.9. Birthplace Tucker Co. W. Va.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Alfred Flanagan13. Birthplace W. Va.14. Maiden name Simon Lambert15. Birthplace W. Va.16. Informant Miss Jay FlanaganAddress Rawling Ind.17. Burial Date thereof Jan 31 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bice Cem.Location Near Rawlings Ind.18. Funeral director Louis Stein Inc.Address Wm. H. H. H. H.19. 1/31/ 19 46 Registrar W. H. H. H.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29th. 19 46 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Due to

Other conditions Suspected Angina Pectoris

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Prune H. Brown M.D.Address Cumberland, Maryland. M. D. or other _____
Date signed 1-29-46

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 2 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

00027

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County... Allegheny
 City or town... Lawrenceville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 68 years
 Hospital, institution, or street address where death occurred:
Allegheny Street
 How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Allegheny
 City or town... Lawrenceville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Allegheny Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war... 0

3. (a) FULL NAME

Mary Catherine Flynn

3. (b) Social Security Number

L

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife John Flynn
 7. Birth date of deceased (mo., day, yr.) July 31, 1874 8.(c) If alive, give age 68 years
 8. AGE: Years 71 Months 5 Days 21 If less than one day hrs. min.

9. Birthplace... Germany
 (Town, county, and state)
 10. Usual occupation... Housework
 11. Industry or business Own home
 12. Name... Martin Scharesky
 13. Birthplace Germany
 14. Maiden name Unknown
 15. Birthplace Germany

16. Informant Mr. Joseph Flynn
 Address Lonaconing Md.
 17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan 25, 1946
 (month) (day) (year)
 Cemetery or crematory St. Mary's Cemetery
 Location Lonaconing Md.
 18. Funeral director Dr. Eishhorn
 Address Lonaconing Md.
 19. Jan. 25 19 46 Dr. E. Don Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 19 46 at 2 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 19...
 and that I last saw her alive on January 22 19 46

Immediate cause of death

Coronary occlusion
sudden death in bed

Due to

influenza

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. E. Don M. D. or otherAddress Lonaconing Date signed 1/25/46

RECEIVED

RECEIVED

RECEIVED

JAN 28 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124

00028

CERTIFICATE OF DEATH

Reg. Dist. No. 9

I. PLACE OF DEATH:

County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

St. Mary's HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Lanacoring
(If outside city or town limits, write RURAL and give nearest town)Street No. 1

(If rural, give LOCATION)

2.(a) If veteran, name war 1

3. (a) FULL NAME

Agnes Luyann Foote

3. (b) Social Security Number

14. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife John J. Foote7. Birth date of deceased (mo., day, yr.) March 11, 1883 6. (c) If alive, give age 75 years8. AGE: Years 62 Months 9 Days 24 If less than one day hrs. min.9. Birthplace Lanacoring, Allegany Co., Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name John J. Luyann13. Birthplace Lanacoring, Md.14. Maiden name May Walker15. Birthplace Lanacoring, Md.16. Informant Yma Raymond DitzAddress Lanacoring, Md.17. Funeral Date thereof Jan 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg, Md.18. Funeral director Dr. BickhornAddress Lanacoring, Md.19. 1-8 19 46 Mr. Nancy D. Ditz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 19 46 at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 19 46 to Jan 5 19 46and that I last saw him alive on Jan 5 19 46Immediate cause of death sub acutecholecytosisDURATION 2 wksDue to cholecytosisDue to cholecytosisOther conditions cholecytosis

RECEIVED

RECEIVED

RECEIVED
JAN 11 1946
RECEIVED V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

CERTIFICATE OF DEATH

Reg. Dist. No. 00029

1. PLACE OF DEATH:

County... Allegany
 City or town... Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs.
 Hospital, institution, or street address where death occurred:
434 Hammond St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md. County... Allegany
 City or town... Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 434 Hammond St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Catherine Mercedes Footen

3. (b) Social Security Number

213-22-3543

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) June 19, 1923

8. AGE: Years 22 Months 7 Days 2 If less than one day
 ... hrs. ... min.

9. Birthplace... Westernport-Allegany-Md.
(Town, county, and state)10. Usual occupation... Laborer11. Industry or business... Textile Plant12. Name... Thomas Footen13. Birthplace... Barton, Md.14. Maiden name... Elizabeth Darr15. Birthplace... Piedmont, W.Va.16. Informant... Edgar FootenAddress... Westernport17. Burial... Burial Date thereof... Jan. 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... St. PetersLocation... Westernport, Md.18. Funeral director... Ellsworth S. BoalAddress... Westernport, Md.19. Jan. 24 19 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan. 21, 19 46 at 10:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 45 to Jan 21 19 46and that I last saw him alive on June 24 19 46Immediate cause of death... Chronic Pulmonary tuberculosis

DURATION

10 mo

Due to...

Due to...

Other conditions... Pneumonia 1 day

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Norman Rees, M.D. M. D. or otherAddress... Westernport Md. Date signed... 1-24-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 26 1946

BUREAU VIR

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00030

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

4 Altamont Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MorganCity or town Barkley Springs
(If outside city or town limits, write RURAL and give nearest town)Street No. Washington St.
(If rural, give LOCATION)

2. (u) If veteran, name war

3. (a) FULL NAME

Ida Elley Gilpin

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed8. (b) Name of husband or wife Dr. Joseph Gilpin

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 13, 1864

8. AGE:

Years

Months

Days

If less than one day

81828

hrs.

min.

9. Birthplace

Morgan Co. W. Va.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

12. Name

William Silver

13. Birthplace

W. Va.

14. Maiden name

Courtney

15. Birthplace

W. Va.

16. Informant

Mrs. Dara Hoffman

Address

Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 14, 1946
(month) (day) (year)

Cemetery or crematory

Greenway Cemetery

Location

Barkley Springs, W. Va.

18. Funeral director

John J. Hofer

Address

Cumberland, Md.

19. Jan 18

(Date rec'd by registrar)

19. 46

Joe. B. Franklin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 19 46, at 119 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10 19 46, to Jan 11 19 46and that I last saw him alive on Jan. 11 19 46

Immediate cause of death

Myocardial infarction

DURATION

Due to

Chronic heart disease3 yrs

Due to

Chronic nephritis3 yrs

Other conditions

✓

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ph. A. Brown

M. D. or other

Address

Cumberland MdDate signed 4-1-3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JAN 15 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00031

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....45 yrs.
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?.....7 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....MARYLAND County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....HENDRICKS HOTEL
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

CHARLES GOODNOW

3. (b) Social Security Number

None

4. Sex.....MALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....Widowed
 6.(b) Name of husband or wife.....Hallie Badgler
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....Aug 15, 1877
 8. AGE: Years.....68 Months.....5 Days.....11 If less than one day..... hrs..... min.

9. Birthplace.....Grafton Taylor Co. W. Va.
 (Town, county and state)

10. Usual occupation.....Barber

11. Industry or business.....Own Business

FATHER 12. Name.....Goodnow

13. Birthplace.....Grafton W. Va.

MOTHER 14. Maiden name.....Hadley Kelly

15. Birthplace.....Grafton W. Va.

16. Informant.....MEMORIAL HOSPITAL

Address.....CUMBERLAND, MD.

17. Burial Date thereof.....Jan 29, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Greenmont Cemetery

Location.....Cumberland Md.

18. Funeral director.....John J. Hager

Address.....Cumberland, Md.

19. Jan. 29, 1946 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....JAN. 26, 1946 10:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

.....19..... to.....JAN. 26, 1946

and that I last saw him alive on.....JAN. 26, 1946

Immediate cause of death.....Terminal

Pneumonia DURATION.....few days

Due to.....Chronic myocarditis ?

Due to.....Hypertensive Ht Dis. ?

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....None Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....C. Minkin M.D. M. D. or other

Address.....115 South Centre St. Date signed.....27 Jan 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 3 1946
BUREAU V. S.

Within corporate limits E. B. Owens
AGE CHANGE: Dr's auth.
filmed 2-25-46 G100 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

00032

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 Virginia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Agnes Hahne

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife George Hahne
6.(c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) June 28 1885
8. AGE: Years 60 Months 6 Days 10 If less than one day
hrs. min.

9. Birthplace Hyndman, Pennsylvania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Meyers

13. Birthplace Pa.

14. Maiden name Nancy

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Jan 11 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter's Cem.

Location Cumberland

18. Funeral director Horn's Stein Inc

Address Cumberland

19. Jan. 10, 1946 J.P. Traubner, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1946 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1945 to Jan 8 1946
and that I last saw him alive on Jan 8 1946

Immediate cause of death Cerebral apoplexy
arterio sclerosis

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. B. Owens M. D. or other

Address 1330a am Date signed 1/9/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1946

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Diat. No.

4

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 yrs.

Hospital, institution, or street address where death occurred:

27 Browning St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Cambria

City or town Altoona
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.T.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Emma Hammers

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Franklin B. Hammers

7. Birth date of deceased (mo., day, yr.) Oct 19, 1860

6.(c) If alive, give age years

8. AGE: Years 85 Months 2 Days 24 If less than one day hrs. min.

9. Birthplace Frugality Cambria Co, Pa
(Town, county, and state)

10. Usual occupation housework

11. Industry or business at home

12. Name Stacey Johnson

13. Birthplace New Jersey

14. Maiden name Sarah Bell Hooper

15. Birthplace Bellefonte Pa.

16. Informant Mrs Hazel Wiley

Address Cumberland Ind

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 15, 1946
(month) (day) (year)

Cemetery or crematory Antis Cemetery

Location Near Pinecroft Rd

18. Funeral director John J. Baker

Address Cumberland Ind.

19. Jan. 13, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13, 1946 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 24 to Jan 13

and that I last saw her alive on Jan 13

Immediate cause of death

chronic valvular heart disease
arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. B. Brown M. D. or other

Address 1330 W. ... Date signed 1/13/46

RECEIVED
JAN 22 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

904 Glenwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
City or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 904 Glenwood St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Fox Heavner

3. (b) Social Security Number

213-12-9635

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Married6. (b) Name of husband or wife Bernice Findley6. (c) If alive, give age 50 years7. Birth date of deceased (mo., day, yr.) June 9, 18858. AGE: Years 60 Months 7 Days 15 hrs. min.9. Birthplace Monrofield-Hardy Co. W. Va
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business General Carpentry12. Name Baron Heavner13. Birthplace Hardy Co. W. Va.14. Maiden name Ella Going15. Birthplace Hardy Co. W. Va.16. Informant Geo R. HeavnerAddress 220 Grand Ave - Chamb. Md.17. Burial Date thereof Jan 26 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Ashby CemeteryLocation Fort Ashby W. Va.18. Funeral director John J. BakerAddress Chamberland Md.19. Jan 26 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1946 46 7:54 PM

21. I CERTIFY that death occurred on the date above stated; that it followed deceased from

Jan. 1, 1946 to Jan. 24, 1946and that I last saw him alive on Jan 22, 1946Immediate cause of death Baron's of Esophagus

DURATION

Sep. 1945

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton J. Furness M. D. or otherChamberland 1-24-46

Address Date signed

RECEIVED
JAN 30 1946
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 1312
CERTIFICATE OF DEATH

00035

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 mo
Hospital, institution, or street address where death occurred 220 Valley St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 220 Valley St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna Mary Helker
3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept 27 1883
6. (c) If alive, give age years

8. AGE: Years 62 Months 4 Days 2
If less than one day hrs. min.

9. Birthplace Cumberland Ind.
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business at home

12. Name Henry Helker
13. Birthplace Ind.

14. Maiden name Lucy Abouse
15. Birthplace Ind.

16. Informant Henry G Helker
Address Cumberland

17. Burial Date thereof Feb 1 46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Peter & Pauls Ch

Location Cumberland

18. Funeral director Johns Stein, Inc
Address Cumberland

19. Jan 31 46 Registrar J P Franklin M.D
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946 at 10:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Chronic Myocarditis DURATION 2 yrs.

Due to

Due to

Other conditions Chr. Nephritis 1 yr.
(a mental case)

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results no autopsy Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James H. Boyson M.D
Address Cumberland, Maryland M. D. or other 1-30-46

Address Allegheny Co.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 5 1946

BUREAU V.B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

00036

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 61 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 112 Karns Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Isabelle Hess

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

8.(b) Name of husband or wife Charles H. Hess

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 16, 1886

8. AGE: Years Months Days If less than one day

59 10 20 _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John P. Orndoff13. Birthplace Ind.14. Maiden name Annq ~~q~~ Todd15. Birthplace Ind.16. Informant John C. HessAddress Cumberland17. Burial Date thereof 1/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Stillcrest CemLocation Cumberland Ind.18. Funeral director Louis Stein IncAddress Cumberland19. Jan 9 1946 Registrar J. C. Orndoff
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1946 at 2:37 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11 1942 to January 6 1946and that I last saw him alive on January 5 1946

Immediate cause of death

carcinoma of the pancreas head

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations metastasis in the liverDate of op. 1-5-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE L. K. Orndoff MD M. D. or otherAddress Louis Stein Inc Date signed 1-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 15 1946
BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

Allegheny Co InfirmaryHow long in hospital or institution? 7 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Spring Gap
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles E. Hetrick

3. (b) Social Security Number

None4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Mary Engle

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb 10 18618. AGE: Years 84 Months 11 Days 0 If less than one day _____ hrs. _____ min.9. Birthplace Clearfield County, Pa.
(Town, county, and state)10. Usual occupation Farming (Retired)11. Industry or business General Farming12. Name Harby Hetrick13. Birthplace Pennsylvania14. Maiden name Elizabeth Hoffman15. Birthplace Pennsylvania16. Informant Mrs Anna AshenfelterAddress 31 Sommerville Ave - Camb17. Burial Date thereof Jan 12 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forest Glenn Beth. CemLocation Green Spring, W. Va.18. Funeral director John J. HoferAddress Cumberland, Md.19. Jan. 18 46 J. P. Hanklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1946, at 11:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/4/46 1946 to 1/10/46 1946and that I last saw him alive on 1/10/46 1946

Immediate cause of death _____ DURATION _____

Pneumoniabronchitis

Due to _____

aspirin

Due to _____

aspirin

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. or other _____

Address Medical Bldg Date signed 1/12/46

MARGIN RESERVED FOR BINDING

I

VS 1151 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D. R. L.

RECEIVED

JAN 15 1946

BUREAU OF

Within corporate limits

DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

00038

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred

MEMORIAL HOSPITALHow long in hospital or institution? 4 hrs 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. WINDSOR HOTEL
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. ELMER E. JOHNSON

3. (b) Social Security Number

440-10-1131

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED8. (b) Name of husband or wife MOLLIE ZIMMERLY

7. Birth date of

deceased (mo., day, yr.)

about 1865

8. AGE:

Years

Months

Days

It less than one day

80

.....hrs.min.

9. Birthplace MARYLAND
(Town, county, and state)10. Usual occupation CARPENTER

11. Industry or business

For Building Contractors

FATHER

12. Name

CHESTON JOHNSON

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

LOUISA JACKSON

15. Birthplace

MARYLAND16. Informant MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.17. Removal Date thereof Jan 21 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Greenwood Cem

Location

Youngstown, Ohio

18. Funeral director

Emil Stein Inc

Address

Cumberland19. Jan. 21 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH JAN. 20, 1946 at 11:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 20, 1946, to 19and that I last saw him alive on JAN. 20, 1946

Immediate cause of death

Fracture left Parietal bone

DURATION

4 hrs.,50 min.

Due to.....

Due to.....

Other conditions

Fract. left arm; mult.
contus. and abrasions.

(Include pregnancy within 8 months of death)

Major findings of operations. ---

.....Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-20-46Where did injury occur? Cumberland, Allegany, Maryla
(City or town) (County) (State)Injured at home, farm, industry, public place (where)? R. R. CrossingMeans of injury struck by loco Injured at work? no

23. SIGNATURE

Elmer H. Boush, M.D.

M. D. or other

Address Cumberland, Maryland Date signed 1-20-46Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

432 Grand Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 432 Grand Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Francis Joyce

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Ellen Rowan

7. Birth date of deceased (mo., day, yr.)

Apr. 23, 1869

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

76826

hrs. min.

9. Birthplace

Terra Alta, W. Va.

(Town, county, and state)

10. Usual occupation

Retired Conductor

11. Industry or business

B. & O. R.R. Co.

FATHER

12. Name

Edward Joyce

13. Birthplace

Ireland

MOTHER

14. Maiden name

Ellen Ward

15. Birthplace

Ireland

16. Informant

Mr. Edward JoyceAddress 432 Grand Ave. Cumberland, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof Jan. 23, 1946
(month) (day) (year)

Cemetery or crematory

St. Patrick's Cem.

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

Jan. 22, 1946J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19, 1946 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 17, 1946 to Jan. 19, 1946
and that I last saw him alive on Jan. 19, 1946

Immediate cause of death

Chronic nephritis

DURATION

2 yr

Due to

arteriosclerosis18 yr

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.
Address 1362 Ave. S. Cumberland, Md. Date signed 1/24/46

MARY AND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEATH OF

DEPARTMENT OF HEALTH

RECEIVED
JAN 30 1946
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

00040

2411 N. Charles St., Baltimore 83-27

DR ELIASON

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 DAYS
 Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL
 How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....MD..... County.....ALLEGANY
 City or town.....CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....637 SHRIVER AVE.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

GOLDIE S. SILVERMAN KAPLON

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

ROBERT KAPLON

7. Birth date of

deceased (mo., day, yr.)

JULY 18 - 1893

6. (c) If alive, give age 60 years

8. AGE:

Years

Months

Days

If less than one day

52

6

1

hrs.

min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

Own Home

FATHER

12. Name

LOUISE SILVERMAN

13. Birthplace

Lithuania

MOTHER

14. Maiden name

Rachel Steinberg

15. Birthplace

Lithuania

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17. Burial

Date thereof Jan. 21, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory

Eastview Cem.

Location

Cumberland, Md.

18. Funeral director

John J. Rafer

Address

Cumberland, Md.

19.

Jan. 21, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....JANUARY 19.....1946.....at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-17-1946, to 1-19-1946
and that I last saw him alive on 1-19-1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 day

Due to

Altered Senility

Due to

Hypertension

4 yrs

15 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.
136 Thront Cumberland Md
Date signed 1/19/46

RECEIVED

JAN 30 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 872

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County alleganyCity or town Frankfort
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

24 water st

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleganyCity or town Frankfort
(If outside city or town limits, write RURAL and give nearest town)Street No. 24 water
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Annie Kemp

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

John Kemp

7. Birth date of deceased (mo., day, yr.)

Mar. 23 - 1870B. (c) If alive, give age 75 years

8. AGE:

Years

Months

Days

If less than one day

75100

hrs.

min.

9. Birthplace

Borden Shelt - alleg - md.
(Town, county, and state)

10. Usual occupation

Invalid

11. Industry or business

FATHER
MOTHER

12. Name

Charles Thomas

13. Birthplace

England

14. Maiden name

Harrist Phipps

15. Birthplace

England

16. Informant

Mr. Grant Giest

Address

Frankfort, md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Jan 26 - 1946
(month) (day) (year)

Cemetery or crematory

allegany

Location

Frankfort, md.

18. Funeral director

J. J. Duck

Address

Frankfort, md.

19.

1-26
(Date rec'd by registrar)

19

46 Mrs. Nancy H. De

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 19 46 at 6:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 9 19 46 to Jan 23 19 46
and that I last saw him alive on Jan 9 19 46

Immediate cause of death

Paralytic agitations

DURATION

many years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. M. Lane

M. D. or other

Address

Frankfort md

Date signed

1-25-46

RECEIVED
JAN 29 1946
BUREAU V.B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00042

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

123 Independence Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 123 Independence Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOSEPH EDWARD KERBER

3. (b) Social Security Number

214-05-8896

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) March 11, 1874

8. AGE:

Years

Months

Days

If less than one day

711013

hrs.

min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)10. Usual occupation Painter (Retired)

11. Industry or business

12. Name Adam Kerber13. Birthplace Germany14. Maiden name Elizabeth Bernard15. Birthplace Germany16. Informant Miss Gertrude FleckensteinAddress 123 Independence St. Cumberland, Md.17. Burial Date thereof Jan. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & PaulsLocation Cumberland, Maryland18. Funeral director William H. KightAddress Cumberland, Maryland19. Jan. 26 19 46
(Date rec'd by registrar)J. P. L. L. L.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24- 19 46 at 59 M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10-12- 19 45 to 1-24- 19 46and that I last saw h. 2 alive on 1-15- 19 46

Immediate cause of death

congestion heart failure

DURATION

one yearDue to chronic myocarditismanyDue to coronary atherosclerosisyears

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. H. King MD M. D. or otherAddress Long Hill Date signed 1-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1946

BUREAU VE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
City or town Conaconnick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: Allegany Street
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Conaconnick, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Allegany Street
(If rural, give LOCATION)
2.(a) If veteran, name War 1

3. (a) FULL NAME

Maria Pritchard Kruppenberg

3. (b) Social Security Number

1

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Frederick Kruppenberg

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1865 B.(c) If alive, give age 2 years

8. AGE: Years 80 Months — Days 18 If less than one day hrs. min.

9. Birthplace Conaconnick, Allegany, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Carpenter

12. Name David Pritchard

13. Birthplace Idaho

14. Maiden name Louisa White

15. Birthplace England

16. Informant Mrs. James Park

Address Conaconnick, Md

17. Burial Date thereof Jan 17, 1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Conaconnick, Md

18. Funeral director Dr. E. J. O'Connell

Address Conaconnick, Md

19. Jan 16 1946 Dr. E. J. O'Connell

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14th 19 46 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 45 to Jan. 14 19 46
and that I last saw him alive on Jan 13 19 46

Immediate cause of death Broncho-Pneumonia DURATION 1 day

Due to arterio-sclerosis

Due to

Other conditions admitted
Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. E. J. O'Connell M. D. or other

Address Conaconnick Date signed Jan 16-1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 18 1946
BUREAU U.S.

NOITA

With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

CERTIFICATE OF DEATH

00044

4

Reg. Dist. No.

1. PLACE OF DEATH:

County..... AlleganyCity or town..... Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 50 yrs

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution?..... 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... AlleganyCity or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No..... 140 N. Centre St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Miss Mary Jane Lindsay

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) April 22nd, 1871

8. AGE: Years Months Days If less than one day

7493

..... hrs. min.

9. Birthplace..... Williamsport Md.
(Town, county, and state)10. Usual occupation..... Sales lady - (retired)11. Industry or business..... Dept. Store12. Name..... James V. Lindsay13. Birthplace..... Md.14. Maiden name..... Lucy Ward15. Birthplace..... Md.16. Informant..... John C. LindsayAddress..... Cumberland Md.17. Burial Date thereof..... 1/28/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory..... GreenmountLocation..... Cumberland Md.18. Funeral director..... Paris Stein Inc.Address..... Cumberland Md.19. Jan. 28, 1946 J. O. Franklin
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1/25 19 46, at 5:55 PM21. I CERTIFY that death occurred on the data above stated; that I attended deceased from January 14 19 46, to January 25 19 46 and that I last saw him alive on January 25 19 46Immediate cause of death..... Heart failure

DURATION

2 daysDue to..... cholesterolcholesterolDue to..... gallstone

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... common duct stone
Date of op. 1-23-46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury..... Injured at work?

23. SIGNATURE..... C. K. Stein MD

M. D. or other

Address..... Long Mdr Date signed..... 1-26-46

RECEIVED

FEB 5 1946

BUREAU V S

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00045

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 139 REYNOLDS ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MR. JAMES E. LITTLE

3. (b) Social Security Number

214-05-7961

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife Cora H. Trigg Little7. Birth date of deceased (mo., day, yr.) Sept. 26, 18786. (c) If alive, give age 62 years

8. AGE:

Years

Months

Days

If less than one day

67311

hrs.

min.

9. Birthplace Spring Gap, Allegany Co., Md.
(Town, county, and state)10. Usual occupation MURPHY'S FIVE & TEN CENT STORE11. Industry or business Night Watchman

FATHER

12. Name

HIRAM LITTLE

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

CATHERINE HERPICK

15. Birthplace

GERMANY

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof Jan. 10, 1946
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md

18. Funeral director

John J. Fisher

Address

Cumberland, Md.

19.

Jan. 10, 1946
(Date rec'd by registrar)

19

46

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 7, 1946 at 1:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 4, 1946 to JAN. 7, 1946and that I last saw him alive on JAN. 7, 1946

Immediate cause of death

Acute Dilatation Left Ventricle

DURATION

1 day

Due to

Pleural Effusion
Emphysema (right)48 days?

Other conditions

Labor pneumonia (left)
Sept.3 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James J. Franklin
M. D. or other

Address

155. Liberty St.

Date signed

1/9/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1946

BUREAU OF

CERTIFICATE OF DEATH

00046 4
Reg. Dist. No.

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....4 days
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?.....4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY
 Near.....CUMBERLAND (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....LA VALE
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. ANTHONY L. LOGSDON

3. (b) Social Security Number

214-05-9713

4. Sex.....MALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....WIDOWED

6.(b) Name of husband or wife.....ROSALIE KUHLMAN

7. Birth date of deceased (mo., day, yr.).....JUNE 22 1889 6.(c) If alive, give age..... years

8. AGE: Years.....56 Months.....6 Days.....25 If less than one day..... hrs. min.

9. Birthplace.....MARYLAND
 (Town, county, and state)

10. Usual occupation.....LABORER11. Industry or business.....LUMBER CO.12. Name.....WILLIAM R. LOGSDON13. Birthplace.....MARYLAND14. Maiden name.....MARTHA HALLER15. Birthplace.....MARYLAND16. Informant.....MEMORIAL HOSPITALAddress.....CUMBERLAND, MD.

17. Burial Date thereof.....Jan 21 46
 (Burial, cremation, or removal. Which)..... (month) (day) (year)

Cemetery or crematory.....St Peter & Pauls Cem.Location.....Cumberland18. Funeral director.....Louis Stein Inc.Address.....Cumberland19. 1/19/46 19. 46 J.P. Hauke, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....1-17-46 at.....46 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
JAN. 13, 1946 to.....JAN. 17, 1946

and that I last saw him.....11 AM on.....JAN. 17, 1946Immediate cause of death.....Sudden UnsymptomaticCoronary FibrosclerosisHeart Disease

Due to.....

Existent ThyroidectomyDue to.....withintra tracheal tube

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....Simplex Heart DiseaseAutopsy results.....nothing Unusual

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured of work?.....

23. SIGNATURE.....A. H. Hawkins

M. D. or other.....

City.....1-18-46

Date signed.....

RECEIVED

JAN 22 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... MT. SAVAGE
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

LOGSDON, RICHARD MR.

3.(b) Social Security Number

712-14-1697

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE white SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) DEC. 22, 1887 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
58 1 0 hrs. min.9. Birthplace MD. Mt. Savage, Alleg. Co.
(Town, county, and state)

10. Usual occupation CARMAN B&O R.R. CO.

11. Industry or business

12. Name JOHN LOGSDON

13. Birthplace Maryland

14. Maiden name ANNIE MARY C. Carlin

15. Birthplace MD.

16. Informant Edward B. Logsdon

Address Mt. Savage, Md.

17. Burial Date thereof Jan. 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Patrick's Cmn

Location Mt. Savage, Md.

18. Funeral director Louis Heta, Inc

Address Cumberland, Md.

19. Jan. 23, 1946 J.P. Frankish M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

5:35

20. DATE OF DEATH JANUARY 22, 1946 19 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/21 to 1/22

and that I last saw him alive on 1/22

Immediate cause of death acute Dilatation of heart. DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.P. Frankish M.D. M.D. or other

Address Cumberland, Md. Date signed 1/23/46

RECEIVED

JAN 30 1946

BUREAU V B

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 51-9-1Hospital, institution, or street address where death occurred:
In Route to Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1019 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Walter F. Long

3. (b) Social Security Number

717-10-6847

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Ernest T. White

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1894

8. AGE: Years 51 Months 9 Days 1 If less than one day hrs. min.

9. Birthplace Cumberland Ind.
(Town, county, and state)10. Usual occupation Meat Cutter11. Industry or business grocery store.12. Name Jerry Long13. Birthplace Ind.14. Maiden name Evelyn15. Birthplace Ind.16. Informant Wm. F. LongAddress Cumberland17. Burial Date thereof Jan 17 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland18. Funeral director Louis Stein IncAddress Cumberland19. Jan 17 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15th, 19 46, at 11 25 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Angina PectorisDURATION
20 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phineas H. Bowman M.D.Address Cumberland, Maryland. Date signed 1-15-46Deputy Medical Examiner - Allegany Co.

RECEIVED

JAN 22 1946

BUREAU

RECEIVED

JAN 22 1946

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00049

4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... AlleganyCity or town... Summerville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 monthsHospital, institution, or street address where death occurred: County PrisonHow long in hospital or institution? 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleganyCity or town... Summerville
(If outside city or town limits, write RURAL and give nearest town)Street No... Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Conrad Lutz

3. (b) Social Security Number

None4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Emma C. Lutz6. (c) If alive, give age 75 years7. Birth date of deceased (mo., day, yr.) January 16, 18558. AGE: Years 90 Months 0 Days 1
It less than one dayhrs.min.9. Birthplace Rawlings, Allegany Co. Md.
(Town, county, and state)10. Usual occupation Merchant - Retired11. Industry or business Own business12. Name Fred Lutz13. Birthplace Germany14. Maiden name Barbara15. Birthplace Germany16. Informant Mrs. Leta FullerAddress Summerville, Md.17. Burial Date thereof January 21, 1946
(Burial, cremation, or removal, Which? (month) (day) (year))Cemetery or crematorium Eltham CemeteryLocation Brookside, Md.18. Funeral director M. E. EickmanAddress Summerville, Md.19. Jan 18, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17- 19 46, at 3 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-17-45 19 45 to 1-16- 19 46and that I last saw him alive on 1/16/46 19 46Immediate cause of death Myocardial infarctionDue to confinement of age and atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. J. Williams, M.D.Address Summerville, Md. Date signed 1/18/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

00050

Reg. Diat. No. 9

1. PLACE OF DEATH:

County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 yrs

Hospital, institution, or street address where death occurred:

Spencer's HospitalHow long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town P.O. Box 2 Box 129 Frostburg, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. Frostburg
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Samuel McKenzie

3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Annie Stark McKenzie6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) Oct. 2 - 18718. AGE: Years 74 Months 3 Days 9 If less than one day8. AGE: Years 74 Months 3 Days 9 If less than one day8. AGE: Years 74 Months 3 Days 9 If less than one day8. AGE: Years 74 Months 3 Days 9 If less than one day8. AGE: Years 74 Months 3 Days 9 If less than one day8. AGE: Years 74 Months 3 Days 9 If less than one day9. Birthplace Frostburg, Md
(Town, county, and state)10. Usual occupation Miner11. Industry or business Coal Miner12. Name John McKenzie13. Birthplace Frostburg, Md14. Maiden name Marjett Gayman15. Birthplace Frostburg, Md16. Informant John L. McKenzieAddress P.O. Box 2 Box 129 Frostburg17. Burial Date thereof 1-14-1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory AlleghenyLocation Frostburg, Md18. Funeral director James E. BakerAddress Frostburg, Md19. 1-14 19 46 New Laney St. Ave
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 19 46 at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 9 19 46 to Jan 11 19 46and that I last saw him alive on Jan 11 19 46

Immediate cause of death

Cerebral HemorrhageLeft HemiplegiaDURATION 6 DaysDue to Arterio SclerosisDue to special

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE WDM Lane Jr MDAddress Frostburg MdDate signed Jan 12 1946

RECEIVED
JAN 17 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6.(d) Single, married, widowed, or divorced

8.(b) Name of husband or wife

6.(c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

January 4,

1946, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 20,

1945, to Jan. 4,

1946

and that I last saw him alive on Jan. 3,

1946

Immediate cause of death

Chronic nephritis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henry M. Hody

M. D. or other

Address

Lanacoring, Md.

Date signed

Jan 4/46

RECEIVED
JAN 7 1946
BUREAU V.B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00052

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
327 Cumberland St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No... 327 Cumberland St.
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME
Margaret Virginia Metz

3. (b) Social Security Number
None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Charles E. Metz

7. Birth date of deceased (mo., day, yr.) July 31, 1870
6. (c) If alive, give age... years

8. AGE: Years 75 Months 5 Days 17 hrs. min.

8. Birthplace Pleasant Valley, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John D. Fisher
13. Birthplace Maryland

14. Maiden name Margaret Cresap
15. Birthplace Maryland

16. Informant Mr. John C. Metz
Address 327 Cumberland St. Cumberland, Md

17. Burial Date thereof Jan. 21, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. Jan. 19, 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/18/46 to 1/18/46
and that I last saw him alive on 1/18/46

Immediate cause of death Chf Myocarditis

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M.D.

Address Cumberland, Md. Date signed 1/19/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 22 1946
BUREAU

RECEIVED
JAN 22 1946
BUREAU

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 13-P
CERTIFICATE OF DEATH

Reg. Diat. No. 000534

1. PLACE OF DEATH:
County Allegany
City or town near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
Homerwood Addition, Rt. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Homerwood Addition, Rt. #1
(If rural, give LOCATION)
2(a) If veteran, name war L

3. (a) FULL NAME
Charles Richard Moody

3. (b) Social Security Number
214-07-0295

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Elizabeth Sheara Moody
7. Birth date of deceased (mo., day, yr.) August 16, 1891 5. (c) If alive, give age 53 years
8. AGE: Years 54 Months 4 Days 26 If less than one day
.....hrs.min.

MEDICAL CERTIFICATION
20. DATE OF DEATH Jan. 12 1946 at 8:15 p. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1946 to Jan. 12 1946
and that I last saw him alive on Jan. 9 1946
Immediate cause of death Pulmonary tuberculosis undeter-
mined
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 8 months of death)
Major findings of operations.....
Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

9. Birthplace Moscow, Allegany Co., Maryland
(Town, county, and state)
10. Usual occupation Electrician
11. Industry or business Kelly Springfield Tire Co.
12. Name William R. Knoff
13. Birthplace Maryland
14. Maiden name Sarah M. Morbey
15. Birthplace Barton, Md.

16. Informant Miss Clara B. Moody
Address Homerwood Addition, Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof January 15, 1948
(month) (day) (year)
Cemetery or crematory Gravel Hill Cemetery
Location Moscow Md.
18. Funeral director Mrs. Eichhorn
Address Frederick Md.
19. Jan. 14 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Charlotte B. Gardner M.D.
M. D. or other
Address Cumberland Md. Date signed 1-13-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-6

00054

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
Allegheny County Infirmary
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 941 Gay St.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME

James Oliver Moore

3.(b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____ 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) October 18, 1867

8. AGE: Years 78 Months 2 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Garrett Co., Md.
(Town, county, and state)

10. Usual occupation Miner (retired)

11. Industry or business coal

12. Name Andrew F. Moore

13. Birthplace Moorefield, W.Va.

14. Maiden name Margaret E. Blacher

15. Birthplace Garrett Co., Md.

16. Informant Mrs. Joseph McSorley

Address Cumberland, Md.

17. Burial Date thereof Jan 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegheny Cemetery

Location Frostburg, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Jan 11, 1946 (Date rec'd by registrar)

Joe O. Franklin
M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1946 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-30-1945 to 1-8-1946 and that I last saw him alive on 1-5-1946

Immediate cause of death Coronary Vascular Disease
Due to Arterio Sclerosis
Due to and infarction
Other conditions age

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Richard D. Williams M. D. or other

Address Cumberland, Md. Date signed 1-9-46

RECEIVED
JAN 15 1946
BUREAU U.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 YearsHospital, institution, or street address where death occurred:
MEMORIAL HOSPITALHow long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 309 N. CENTRE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

MRS. ELLA MYERS

3.(b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED6.(b) Name of husband or wife JOSEPH B. MYERS7. Birth date of deceased (mo., day, yr.) OCT. 14, 1875
6.(c) If alive, give age..... years8. AGE: Years 70 Months 2 Days 19
If less than one day..... hrs. min.9. Birthplace WEST VIRGINIA
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOHN SIGLER13. Birthplace MARYLAND14. Maiden name Rachel Duckworth15. Birthplace Maryland16. Informant MEMORIAL HSOPITAL
Address CUMBERLAND, MD.17. Burial Date thereof Jan. 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany Cemetery
Frostburg, Maryland
Location18. Funeral director William H. Kight
Address Cumberland, Maryland19. Jan. 4, 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 3, 1946 at 2:20 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-28-44 to 1-3-46
and that I last saw him alive on 1-3-46Immediate cause of death Chronic Hepatitis
Diabetes
Mellitus
DURATIONDue to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. NoneAutopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE W.F. Williams M.D. or other
Cumberland Date signed 1-3-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00055

RECEIVED

JAN 8 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

00056

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
16 N. WAVERLY TERRACE
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 16 N. WAVERLY TERR.
 (If rural, give LOCATION)
 2(a) If veteran, name war none

3. (a) FULL NAME

LLOYD Lowdnes Newnam (NEWNAM)

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white MARRIED

6. (b) Name of husband or wife Virginia NEFF

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 16 MAY 1878

8. AGE: Years Months Days It less than one day
67 9 218 hrs. min.

9. Birthplace Piedmont, W. Va.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Charles F. Newnam

13. Birthplace SHANPSBURG MD

14. Maiden name MARY VIRGINIA OPLE

15. Birthplace Frederick, Md.

16. Informant S.J. Newnam

Address 517 Greene St. Cumberland Md.

17. Burial Date thereof Feb. 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peters and Pauls

Location Cumberland, Maryland

18. Funeral director William H. Kight

Address Cumberland, Maryland

19. Jan. 31, 46 J.P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 JAN. 1946, at 9:28p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 January 1946, to 29 Jan 1946

and that I last saw him alive on 29 January 1946

Immediate cause of death CARDIAC FAILURE

DURATION

Due to Cerebral Hemorrhage 7 DAYS

Due to Cerebral Hemorrhage

Other conditions PARALYSIS Complete 29 yrs

left hemiplegia since 1917.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Tuller B. Whitworth MD M. D. or other

Address 112 Bedford St. Date signed 29 Jan 46

Cumberland Md

MARGIN RESERVED FOR BINDING

9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 5 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.Hospital, institution, or street address where death occurred:
40 Pennsylvania Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 40 Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Gilbert Claudius Nine

3. (b) Social Security Number

None4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Orissia E. Nine7. Birth date of deceased (mo., day, yr.) May 3 18798. AGE: Years 66 Months 8 Days 5 If less than one day
hrs. min.9. Birthplace Amherstburg, N. Va.
(Town, county, and state)10. Usual occupation Ry. Conductor11. Industry or business Retired 15 yrs12. Name John M. Nine13. Birthplace N. Va.14. Maiden name Knotts15. Birthplace N. Va.16. Informant John M. NineAddress Cumberland17. Burial Date thereof Jan 14 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Willowcrest Cem.Location Cumberland, Md.18. Funeral director Doris Stein IncAddress Cumberland19. Jan. 14 19 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Probably MEDICAL CERTIFICATION

20. DATE OF DEATH night of 1-8- 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 , to 19 and that I last saw him alive on 19 Immediate cause of death Cerebral hemorrhage

DURATION

Due to Due to Due to Due to Due to Due to Other conditions (body found this afternoon,1-11-46, lived alone)

(Include pregnancy within 3 months of death)

Major findings of operations ---Date of op. Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE James H. Johnson, M.D.Cumberland, Maryland. M. D. or other Date signed 1-11-46

Deputy Medical Examiner - Allegany Co.

ARTIST'S LEDGER

RECEIVED
JAN 22 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-2)

00058

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:
734 Gephart Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 734 Gephart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Laura Alice O'Bryon

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Wellington O'Bryon

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1865 6. (c) If alive, give age years

8. AGE: Years 80 Months 1 Days 25 If less than one day hrs. min.

9. Birthplace Ruby N.Y.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jeremiah Mower

13. Birthplace New York

14. Maiden name Laura Carle

15. Birthplace New York

16. Informant Mrs. David Jobson

Address 734 Gephart Drive Cumberland, Md.

17. Burial Date thereof Jan. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Marion Cem.

Location Mt. Marion, N.Y.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Jan. 23, 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 - 1946 to Jan. 28, 1946 and that I last saw him alive on Jan. 22, 1946

Immediate cause of death Chronic degenerative Chronic myocarditis

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death.)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.P. Franklin, M.D.

Address 672 Peach St. Cumberland, Md. Date signed 1-23-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1946

BUREAU V E

CERTIFICATE OF DEATH

Reg. Dist. No. 00059 4

1. PLACE OF DEATH:

County..... AlleganyCity or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia County MorganCity or town..... Paw Paw
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Richard Peters

3. (b) Social Security Number

None4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 18, 19338. AGE: Years 12 Months 11 Days 17 It less than one day
..... hrs. min.9. Birthplace..... W. Virginia
(Town, county, and state)10. Usual occupation..... Student

11. Industry or business.....

12. Name..... Floyd Peters13. Birthplace..... W. Virginia14. Maiden name..... Dorothy Proudfoot15. Birthplace..... Unknown16. Informant..... Floyd PetersAddress..... Paw Paw, W. Va.17. Burial Date thereof..... Jan. 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Woodrow, W. Va.Location..... Woodrow, W. Va.18. Funeral director..... Louis Steen, Inc.Address..... Cumberland, Md.19. Jan. 7, 1946 J. P. Traublin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 5 19 46 at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/28 19 45 to 1/5 19 46and that I last saw him alive on 1/5 19 46Immediate cause of death..... congestive heart failure DURATION 2Due to..... pneumonic heart disease 1 yr

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Eliza Keefe Brigg, M.D. M. D. or otherAddress..... Comp. ind. Date signed 1/6/46

STANDARD INTERNATIONAL TIME

STANDARD INTERNATIONAL TIME

Handwritten signature

ARTESIAN LEADER

RAC CONTENT

RECEIVED
JAN 15 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1245

00060

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Crumbsland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Maryland County AlleghenyCity or town Crumbsland
(If outside city or town limits, write RURAL and give nearest town)Street No. 232 Frederick St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leona Pope

3. (b) Social Security Number

None4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Dec 25 1913

8. AGE:

Years

Months

Days

If less than one day

32-23

hrs.

min.

9. Birthplace

Ridgely N. Va.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Wm Pope

13. Birthplace

N. Va.

MOTHER

14. Maiden name

Alise M. Redman

15. Birthplace

N. Va.

16. Informant

Wm Pope

Address

Ridgely N. Va.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 20 46
(month) (day) (year)

Cemetery or crematory

Pope Cem.

Location

Frankfort Rd. N. Va.

18. Funeral director

Gomis Stein Inc

Address

Crumbsland

19.

(Date rec'd by registrar)

19.

46J.P. Kautlin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 18

19.

46

at

10:30

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-17

19.

46

to

1-18

19.

46

and that I last saw him alive on

1-18

19.

46

Immediate cause of death

embolism of the liver

DURATION

several

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Brings M.D.

M. D. or other

Address

Long Rd

Date signed

1-19-46

RECEIVED
JAN 22 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 15

1. PLACE OF DEATH:

County mt. AlleganyCity or town mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County alleganyCity or town mt. Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ellen Porter

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 11 - 1867

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

78929

hrs.

min.

9. Birthplace

mt. Savage - alleg - md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Jan 10 - 1946
(Date rec'd by registrar)19. 46Vernice McDermott
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th 1946, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1945 to Jan 9th 1946and that I last saw him alive on January 9th 1946

Immediate cause of death

Myocarditis

DURATION

5 Years

Due to

Multiple ArthritisNone10-20 Years

Due to

Other conditions

Fracture Left hip. (Femur)Due to Accidental fall
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of February 2nd 1945Where did injury occur? mt. Savage Allegany Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of Injury Accidental fall Injured at work?

23. SIGNATURE

William E. Moseley M.D.

M. D. or other

Address mt. Savage md. Date signed 1-10-46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00061

RECEIVED
FEB 3 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-20

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County AlleganyCity or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Bradley Porter

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Florence Lee Porter

7. Birth date of deceased (mo., day, yr.)

March 14, 1863

5. (c) If alive, give age _____ years

8. AGE:

Years 82 Months 10 Days 14
If less than one day _____ hrs. _____ min.

9. Birthplace

Mt. Savage Allegany Cty, Md
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Spoon Keeper

12. Name

Jacob Porter

13. Birthplace

Maryland

14. Maiden name

Mary Mc Grogan

15. Birthplace

Scotland

16. Informant

Charles Noonan

Address

Mt. Savage Md.

17. Burial

Burial Date thereof Jan 31, 1946
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory

St. Patrick's Cemetery

Location

Mt. Savage Md.

18. Funeral director

J. J. Dierckx

Address

Frostburg Md.19. 1/29
(Date rec'd by registrar)19 46Vernon M. Ziemert
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1946 at 7: PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 25, 1946, to January 25, 1946and that I last saw him alive on January 25, 1946

Immediate cause of death

hypertension, C.V. Renal
lesions

DURATION

years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Blair M. Schindler MDAddress 41 E. E. St. Cumberland Md.Date signed Jan 29, 1946

RECEIVED
FEB 3 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Bedford
 City or town Pleasantville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Clyde S. Potts

3. (b) Social Security Number

?

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mae Young 6. (c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) April 22, 1888
 8. AGE: Years 57 Months 9 Days 5 If less than one day hrs. _____ min. _____

9. Birthplace Bedford, Pennsylvania
 (Town, county, and state)

10. Usual occupation Storekeeper

11. Industry or business _____

FATHER 12. Name Theodore Potts
 13. Birthplace Pennsylvania

MOTHER 14. Maiden name Ellen Beckley
 15. Birthplace Pennsylvania

16. Informant Memorial Hospital
 Address Cumberland, Maryland

17. Removal Removal Date thereof January 27, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Pleasantville Cemetery
 Location Pleasantville, Pennsylvania

18. Funeral director J. Clifford Blackburn
 Address Alum Bank, Pennsylvania

19. Jan. 27, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1946 at 12:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-16- 1946 to 1-27- 1946
 and that I last saw him alive on 1-26- 1946

Immediate cause of death myocardial degeneration DURATION _____
arteriosclerosis

Due to _____
 Due to _____

Other conditions uterine strictures
chronic pyelonephritis
 (Include pregnancy within 8 months of death)

Major findings of operations Cystostomy Date of op. 1-16-46

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Howard E. Tolson M. D. or other _____
Cumberland, Md. Date signed 1-27-46
 Address _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00063

RECEIVED
FEB 5 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

CERTIFICATE OF DEATH

Reg. Diat. No. 00064 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 Virginia Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Wm Marshall Pownall

3. (b) Social Security Number

None4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Louise Parsons
6. (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) March 31, 18778. AGE: Years 68 Months 9 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Romney, Hampshire Co. W. Va.
(Town, county, and state)10. Usual occupation Owner11. Industry or business Lumber Business12. Name Arnold Pownall13. Birthplace W. Va.14. Maiden name Mary Shaw15. Birthplace W. Va.16. Informant Mrs Wm M. PownallAddress 305 Va. Ave - Cumberland Md17. Burial Date thereof Jan 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ebenezer CemeteryLocation Near Romney, W. Va.18. Funeral director John J. HaferAddress Cumberland Md.19. Jan. 7, 1946 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4-46 19 4621. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19, 1945 to 1-4-46and that I last saw him alive on 1-3-46 19 46Immediate cause of death Cerebral Hemorrhage DURATION 7Generalized ArteriosclerosisDue to ArteriosclerosisDue to Arteriosclerosis

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. F. Williams M. D. or other _____Address Cumberland Date signed 1-5-46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 15 1946
BUREAU V.S.

Evidence for addition of sex is shown on GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46P

000654

FILM No. I O 1 MAR 19 1946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... ALLEGANY
City or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... GARRETT

City or town... OKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

CHARLES W. PYSELL,

3. (b) Social Security Number

None

4. Sex

76- Male

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife... DORA RODEHEAVER (DECEASED)

7. Birth date of deceased (mo., day, yr.)

November 30, 1875

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

70

1

13

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

COUNTY ROADS

11. Industry or business

Garrett County, Md.

FATHER

12. Name

ANDREW PYSELL

13. Birthplace

MD.

MOTHER

14. Maiden name

MARY BOWSER

15. Birthplace

MD.

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 16, 1946

Cemetery or crematory

Deer Park Cemetery

Location

Deer Park, Md.

18. Funeral director

Address

19.

(Date rec'd by registrar)

Jan. 15, 1946

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... JAN. 13, 1946 19... , at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 26, 1945 to Jan. 13, 1946

and that I last saw him alive on Jan. 13, 1946

Immediate cause of death

Cerebral collapse

Due to

Partial gastrectomy

Due to

Car accident of stomach

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Mass in sigmoid

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. P. Franklin M. D. or other
Cumberland Date signed Jan. 14-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 22 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00666

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

555 Arnett TerraceHow long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 555 Arnett Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank Quattro

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Elise

7. Birth date of

deceased (mo., day, yr.)

January 29, 18816.(c) If alive, give age 56 years

8. AGE:

Years

Months

Days

If less than one day

641113

hrs.

min.

9. Birthplace

Sulmona, Abazia, Italy
(Town, county, and state)

10. Usual occupation

Laborer (Retired 10 yrs.)

11. Industry or business

Coal Mine

FATHER

12. Name

Louis Quattro

13. Birthplace

Sulmona, Abazia, Italy

14. Maiden name

Unknown

15. Birthplace

16. Informant

Arthur M. Quattro

Address

Thomas, W. Va.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 17, 1946
(month) (day) (year)

Cemetery or crematory

Catholic Cem.

Location

Thomas, W. Va.

18. Funeral director

D. D. Duncan

Address

Thomas, W. Va.

19. Date rec'd by registrar

Jan. 15, 1946J. P. Traubler, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

1/13/461946, at 46 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/8/461946to 1/13/461946and that I last saw him alive on 1/12/461946

Immediate cause of death

Arteriosclerosis of heart

DURATION

Due to

Due to

Other conditions

Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. J. Williams
Medical State

M. D. or other

Address

Date signed 1/15/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 22 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 62-6

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Waverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs
 Hospital, institution, or street address where death occurred
408 S Cedar St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Waverly
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 408 S Cedar St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Katherine S Robey

3. (b) Social Security Number

212-12-8816

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MarriedB. (b) Name of husband or wife Theodore Robey

B. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

about 1892

8. AGE:

Years

Months

Days

If less than one day

53-hrs.min.

9. Birthplace

W. Va.

(Town, county, and state)

10. Usual occupation

Lab P Ry Employee

11. Industry or business

office

FATHER

12. Name

James A Harris

13. Birthplace

W. Va.

14. Maiden name

Iuthe A Swannery

15. Birthplace

W. Va.

16. Informant

Theodore Robey

Address

Waverly

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 6 46

Cemetery or crematory

Maris Memorial Cem.

Location

Wlatown Rd.

18. Funeral director

Louis Stein Inc.

Address

Waverly

19.

(Date rec'd by registrar)

19

46Joseph P. Zambelli

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 4th 1946, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 27 1945 to Jan 3 1946and that I last saw him alive on Jan 3 1946

Immediate cause of death

auricular Fibrillation

DURATION

months

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Blane M. Schindler, M.D.

M. D. or other

Address

41 Greene St

Date signed

Jan 7/1946

RECEIVED

JAN 8 1946

BUREAU OF

CERTIFICATE OF DEATH

Reg. Dist. No.7.....

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-

1. PLACE OF DEATH:

County allegany

City or town Cusheband
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:
603 4th Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....md..... County.....allegany.....
City or town.....Cumberland.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 603 md Ave.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Mrs Anna Mildred Robinette 3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	white	married
6. (b) Name of husband or wife		Belmont Robnetta
7. Birth date of deceased (mo., day, yr.)		8. (c) If alive, give age
May 11, 1905		44 years
8. AGE:	Years	Months
40	7	15
		Days
		if less than one day
		hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 43 to Jan 6 1946 and that I last saw him alive on Jan 6 1946

Immediate cause of death Chronic nephritis

DURATION 3 yrs

9. Birthplace Seneca, Allegany Co. N.Y.
(Town, county and state)

10. Usual occupation Housework

Dr. Udo Siepertusovi

Due to _____

Due to _____

11. Industry or business at Home

PAGE 06

12. Name..... Thomas A. Smith

Other conditions

13. Birthplace Tonacoung, Kyd.

(Include pregnancy within 3 months of death)

14. Maiden name Margaret, Haddon

Major findings of operations.....

15. Birthplace Tonawanda, Pa.
B. & R. Co.

Date of op. _____

16. Informant William Howard
1037 1/2 Ave. S.W. 7th

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Address 603 1/2 W. - Lumb. Rd.
Birmingham, Ala. Jan 18 1946

22. **VIOLENCE:** If death was due to external causes, fill in the following:

17. Interment Date thereof 11-22-72
(Burial, cremation, or removal. Which?) (month) (day) (year)

Accident, suicide, or homicide..... Date of

Cemetery or crematory..... Hillcrest Cemetery

Where did injury occur? (City or town) (County) (State)

Location Cumberland Md

Injured at home, farm, industry, public place (where?)

18. Funeral director..... John J. Haller

means of injury Handgun injured at home

Address Culverland, Md.

23. SIGNATURE W. H. Cason, JR.

19 Jan. 10, 1946 J. H. Franklin, M.D.
(Date rec'd by registrar) Registrar

26740008 Cumberland Rd
Address _____ Date signed 1/7/47

RECEIVED

JAN 15 1946

BUREAU V.S.

Evidence for change of
age & birth date of deceased
is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44)

00669

FILM No. 100 JAN 28 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Allegany Hospital
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town McCoole
(If outside city or town limits, write RURAL and give nearest town)
Street No. 43 Queen St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George Benjamin Robison

3. (b) Social Security Number

232-09-8967

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Elsie Clifton Wilkins
5.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1890-1891

8. AGE: Years 54 Months 55 Days 2 If less than one day 15 hrs. min.

9. Birthplace Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Fireman

11. Industry or business Celanese Corp.

FATHER 12. Name George McClellan Robison

13. Birthplace Maryland

MOTHER 14. Maiden name Izora Riley

15. Birthplace Penn.

16. Informant Mrs. Elsie Robison

Address 43 Queen St. McCoole, Md.

17. Burial Date thereof Jan. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Shady Methodist Cem

Location Bean's Settlement, W. Va.

18. Funeral director N.L. Rogers Funeral Directors

Address Keyser, W. Va.

19. Jan. 11, 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 - 1946 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 - 1946 to Jan 11 - 1946
and that I last saw him alive on Jan 11 - 1946

Immediate cause of death Cerebral Arteriosclerosis DURATION 2 Sun

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE O.P. W. Lunsan M. D. or other

Address Cumberland Md Date signed 1-11-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1946

BUREAU OF

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 YEARS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County ALLEGANY
 City or town CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 119 ROBERTS ST., CITY
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

ROCKWELL, EMMA K. MRS.

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

EDWARD ROCKWELL

7. Birth date of deceased (mo., day, yr.)

SEPT 5 1870

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

75

3

28

hrs.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

NONE

11. Industry or business

FATHER

12. Name

SMITH, JOHN

13. Birthplace

Md.

MOTHER

14. Maiden name

BLUBAKER, AMANDA

15. Birthplace

Unknown

16. Informant

Chas. E. Rockwell

Address

Cumberland

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 7 46

Cemetery or crematory

Oak Cem.

Location

Farmers H. Va.

18. Funeral director

Loris Stein Inc.

Address

Cumberland

19.

(Date rec'd by registrar)

Jan 5 1946

Joseph P. Zupka

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

JAN. 3,

19 46,

at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DEC. 26,

1945,

to JAN. 3,

1946

and that I last saw her alive on

Jan. 3

1946

Immediate cause of death

DURATION

Chronic Nephritis
Hypertension

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1-4-46

RECEIVED

JAN 8 1946

BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, Maryland

How long in hospital or institution?

10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rt. #1, Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Francis Rodda Francis Thomas Rodda

3. (b) Social Security Number

168-01-6930

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Vivian Rodda (Gould)

6. (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) July 17th, 1907

8. AGE: Years 38 Months 6 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Pittsburgh, Allegheny, Pa.
(Town, county, and state)

10. Usual occupation Machinist, Celanese

11. Industry or business

12. Name John Rodda

13. Birthplace Pa.

14. Maiden name Essie Lawrence

15. Birthplace Pa.

16. Informant Mrs. Francis T. Rodda

Address Rt. 1, Cumberland, Md.

17. Burial Date thereof January 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Cemetery

Location Pittsburgh, Pa.

18. Funeral director John J. Hoffman

Address Cumberland, Md.

19. Jan 24, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 19 46 at 6:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/27 19 45 to 1/22 19 46 and that I last saw him alive on 1/22 19 46

Immediate cause of death acute leukemia DURATION 2 weeks

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work?

23. SIGNATURE Elisabeth Brings, M.D. M. D. or other

Address Long, Md. Date signed 1/23/46

MARGIN RESERVED FOR BINDING

9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 30 1946
BUREAU OF

John
P. Sullivan
To
General
Home

Being
Yours

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 yrs

Hospital, institution, or street address where death occurred:

817 Hilltop Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 817 Hilltop Drive
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs Elizabeth Rowe

3. (b) Social Security Number

None4. Sex Female5. Color or race white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Thomas Rowe

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 15, 18578. AGE: 88 Years 11 Months 20 Days hrs. min.9. Birthplace Wellersburg Somerset Co, Pa
(Town, county, and state)10. Usual occupation Housework11. Industry or business at home12. Name Wm McLucas13. Birthplace Scotland14. Maiden name Mary McLucas15. Birthplace Scotland16. Informant Mrs Webster EdwardsAddress 817 Hilltop Drive - Cumb. Md.17. Burial Date thereof Jan 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegheny CemeteryLocation Frostburg Md.18. Funeral director John J. HaferAddress Cumberland Md19. Jan. 6, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1946 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1, 1945 to Jan 4, 1946and that I last saw her alive on Jan. 2

Immediate cause of death

Chronic HypertensionChronic NephritisDue to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____Address 252 Penn St. Cumberland Md Date signed 1/4/46

MARGIN RESERVED FOR BINDING

VS A15

9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED TO THE DIRECTOR, FBI, WASHINGTON

RECEIVED TO THE DIRECTOR, FBI, WASHINGTON

RECEIVED TO THE DIRECTOR, FBI, WASHINGTON

RECEIVED

JAN 8 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 230

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 YEARS

Hospital, institution, or street address where death occurred:

220 Hay St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 220 Hay St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Herman Deitrich Sathoff.

3. (b) Social Security Number

220-10-2450

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Helen Fitzpatrick Sathoff6.(c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) March 3, 1889

8. AGE: Years Months Days If less than one day

561012

hrs. min.

9. Birthplace Frostburg Maryland
(town, county, and state)10. Usual occupation Track watchman11. Industry or business Railroad12. Name Deitrich Sathoff13. Birthplace for Germany14. Maiden name Elizabeth Gallagher15. Birthplace Frostburg Md16. Informant Mrs. Helen SathoffAddress 220 Hay St. Cumberland, Md17. Burial Date thereof January 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director John J. HopkinsAddress Cumberland, Md.19. Jan. 18, 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1946 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 6 1946 to Jan 15 1946and that I last saw him alive on Jan 15 1946Immediate cause of death Cerebral hemorrhage

DURATION

90 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. Trevischio, M.D.

M. D. or other

Address Cumberland, Md Date signed 2/17/46

MARGIN RESERVED FOR BINDING

9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 22 1946
BUREAU V. S.

Within corporate limits

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

00074

CERTIFICATE OF DEATH



Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs.
 Hospital, institution, or street address where death occurred:
30 Elder St.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 30 Elder St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war —

3. (a) FULL NAME

Lydia Schad.

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Henry A. Schad 6. (c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) Nov. 9, 1872
 8. AGE: Years 73 Months 7 Days 17 If less than one day — hrs. — min.

9. Birthplace Hedgesville, W. Va.
 town, county, and state

10. Usual occupation Housewife

11. Industry or business at home

12. Name John Miller

13. Birthplace W. Va.

14. Maiden name Mary Robbins

15. Birthplace W. Va.

16. Informant Mrs. Sylvester Pittman

Address Cumberland, Md.

17. Burial Date thereof Jan 30 46
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Hedgesville Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Jan 30 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to Jan 26 1946

and that I last saw him alive on Jan 26 1946

Immediate cause of death Cerebral hemorrhage - rch

DURATION

Due to Right femoral artery

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

Signature Clay E. Jones

23. SIGNATURE — M. D. or other —

Address Cumberland Date signed 1-28-46

RECEIVED
FEB 5 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

00075

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs.
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 23 FIFTH STREET
 (If rural, give LOCATION)
 2.(n) If veteran, name war.....

3. (a) FULL NAME

MRS. ELIZABETH SEE

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife AMOS SEE6. (c) If alive, give age 75 years

7. Birth date of

deceased (mo., day, yr.)

9/18/75

8. AGE:

Years

Months

Days

If less than one day

7057

hrs.

min.

9. Birthplace

PENNSYLVANIA

(Town, county, and state)

10. Usual occupation

WIFE

11. Industry or business

FATHER

12. Name

HAUSRATH, JOHN

13. Birthplace

GERMANY

MOTHER

14. Maiden name

MARTIN, MARGARET

15. Birthplace

GERMANY

16. Informant

Amos See
23-5th St. Cumberland md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1/29/46

(month) (day) (year)

Cemetery or crematory

mt olivet, Fredrick, md

Location

Fredrick Md.

18. Funeral director

Address

Lewis Stein Inc
Cumberland md.

19. Date rec'd by registrar

Jan. 28, 1946J. C. Shaffer
M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 25, 1946 19..... at 10:30A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 719..... to Jan 25

19.....

and that I last saw her..... alive on Jan 25/46

19.....

Immediate cause of death.....

Terminal pneumonia

DURATION

48 hrs

Due to.....

Carcinoma of Rt. Breast. 2 yrs.

Due to.....

Other conditions.....

None

(Include pregnancy within 8 months of death)

Major findings of operations.....

Carcinoma of breastwith metastasesDate of op. June 1945

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (Where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. C. Shaffer
M.D. or other

Address.....

205 Greene St.Date signed 25 Jan/46

RECEIVED
FEB 5 1946
BUREAU V. 8

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY
 City or town... CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 9 days

3. (a) FULL NAME

WILLIAM H. SELLERS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD. County... ALLEGANYCity or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. RESERVOIR AVENUE
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife ETTA HIGH6. (c) If alive, give age 76 years7. Birth date of deceased (mo., day, yr.) JANUARY 30 1898

8. AGE: Years Months Days If less than one day
87 11 28hrs.min.

9. Birthplace MD.
(Town, county, and state)10. Usual occupation WATCHMAN AT FORT HILL RESERVOIR

11. Industry or business

12. Name HIRAM SELLERS13. Birthplace PA.14. Maiden name REBECCA CUREY15. Birthplace PA.16. Informant George SellersAddress 707. Montgomery Ave, Cumberland, Md.17. Burial Date thereof 2/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. Jan 31 1946 J.P. Nauphi, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 28 1946 at 5:23 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-19-46 to 1-28-46
and that I last saw him alive on 1-28-46

Immediate cause of death

Arteriosclerosis

DURATION

Due to.....

Due to.....

Due to.....

Other conditions Chronic nephritis

.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE Howard D. Tolson, M.D.Address Cumberland, Md.Date signed 1-28-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 5 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00077

4

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. VA. County... MINERALCity or town... ROMNEY
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

MRS. CHLOE J. SHAWEN

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife... THOMAS SHAWEN

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) MAY 11, 18728. AGE: Years Months Days If less than one day
73 7 14 hrs. min.9. Birthplace... W. VA.
(Town, county, and state)10. Usual occupation... HWEE

11. Industry or business

12. Name... POLAND, EDWARD I.13. Birthplace... W. VA.14. Maiden name... HOTT, MARY15. Birthplace... W. VA.16. Informant... Memorial Hosp.
Address... Cumberland, Md.17. Burial Date thereof... Jan 8-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... GreenwoodLocation... Romney W. VA.18. Funeral director... Thrush'sAddress... Romney W. VA.19. Jan. 8, 1946 Joseph P. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... JANUARY 5, 1946 at 8:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12:26 1945 to Jan. 5, 1946
and that I last saw him alive on Jan. 5, 1946Immediate cause of death... Embolic
st. brachial
Due to... artery
Due to... chronic valvular
heart disease
Other conditions...
(Include pregnancy within 3 months of death)Major findings of operations... noneDate of op. noneAutopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

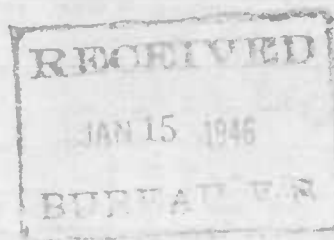
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Wm. F. Williams M. D. or otherAddress... Cumberland Date signed... 1-7-46



DR. REYNOLDS
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

00078

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

6 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 1894 BEDFORD ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Catherine
BAZY GIRL SPOERL

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

JAN. 20, 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6 hrs. 5 min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

FRANK SPOERL

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

LEAH WILLISON

15. Birthplace

MARYLAND

16. Informant

Address

MEMORIAL HOSPITALCUMBERLAND, MD.Cremation

(Burial, cremation, or removal. Which?)

Date thereof Jan. 21, 1946
(month) (day) (year)

Cemetery or crematory

MEMORIAL HOSPITAL

Location

Cumberland, Md.

18. Funeral director

Address

Same

19.

(Date rec'd by registrar)

Jan. 21, 1946J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

JAN. 19, 1946 8:10 PM

20. DATE OF DEATH 19 21 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 19, 1946 to 1946and that I last saw her alive on JAN. 19, 1946

Immediate cause of death

DURATION

Prematurity
congenital defects

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. L. Reynolds, M.D.

M. D. or other

Address

Jan. 20, 1946 Cumberland, Md.
Date signed

RECEIVED
JAN 30 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 9

I. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hrs
Hospital, institution, or street address where death occurred
Miners Hospital
How long in hospital or institution? life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town RFD #2 Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Zihlman
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

John Ronald Stevens

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) January 8, 1946 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
4 hrs. 55 min.

9. Birthplace Frostburg, Md
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name John Robert Stevens

13. Birthplace Zihlman Md

14. Maiden name Keray O'Neal

15. Birthplace Zihlman Md

16. Informant John Robert Stevens

Address Zihlman Md

17. Burial Date thereof Jan 9 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md

18. Funeral director J. J. Smith

Address Frostburg, Md

19. 1-9 46 Mrs. Nancy V. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/8 1946 to 1/9 1946
and that I last saw him alive on 1/8 1946

Immediate cause of death Prematurity
(6 months gestation)

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE Hilda Jane Walker M.D. or other

Address Frostburg, Md Date signed 1/9/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

JAN 11 1946

BUREAU V A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

00080

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
City or town Zanadoring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
East Main Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Zanadoring
(If outside city or town limits, write RURAL and give nearest town)
Street No. E. Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Jennie Lyons Stevenson

3. (b) Social Security Number

—

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Edward Stevenson

7. Birth date of deceased (mo., day, yr.) March 29, 1875 6.(c) If alive, give age 75 years

8. AGE: Years 70 Months 9 Days 9 If less than one day — hrs. — min.

9. Birthplace Barton, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Jacob Lyons

13. Birthplace Ohio

14. Maiden name Juanie Rose

15. Birthplace Springfield

16. Informant Dr. J. J. Mello

Address Zanadoring, Md.

17. Burial Date thereof Jan. 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Maryland

18. Funeral director M. E. Eichhorn

Address Zanadoring, Md.

19. Jan. 9 1946 Dr. J. J. Mello
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1946 at 8:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8, 1946 to Jan. 8, 1946 and that I last saw him alive on Jan. 8, 1946

Immediate cause of death Coronary Occlusion

Due to Angina Pectoris

Due to Hemiplegia aff.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE A. E. Don M. D. or other —
Address Zanadoring Date signed Jan. 9, 1946

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOITA



NOITA

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on **MARYLAND STATE DEPARTMENT OF HEALTH**
2411 N. Charles St., Baltimore 37-2

FILM No. I 00 JAN 24 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? Six days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Little Orleans
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George W. Stottlemeyer

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife _____

B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 29, 1870 18698. AGE: Years Months Days If less than one day
76 76 5 12 _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer (Retired)

11. Industry or business

12. Name Joseph B. Stottlemeyer13. Birthplace Maryland14. Maiden name Christina Zeigler15. Birthplace Maryland16. Informant James StottlemeyerAddress R.D. #1 Little Orleans, Md.17. Burial Date thereof Jan. 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Patricks Cem.Location Little Orleans, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Jan. 11, 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 19 46, at 8: A M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 19 46 to Jan 10 19 46
and that I last saw him alive on Jan 9 19 46

Immediate cause of death _____

Chronic nephritis DURATION 1 yearDue to Enlarged prostateDue to Lgt structure pneumonia
uretersOther conditions Complete retention of urine

(Include pregnancy within 3 months of death)

Major findings of operations Cystostomy only.
Fluge prostate Date of op. Jan 4-46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. St. J. Craskie, M.D. M. D. or otherAddress Cumberland Md Date signed Jan 11-46

RECEIVED

JAN 15 1946

BUREAU V.R.

DR. WILLIAMS

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA. County HAMPSHIRECity or town SPRING GAP, W. VA.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

STRAW, WAYNE MR.

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

WOLFE, MARTHA

7. Birth date of deceased (mo., day, yr.)

March 30, 19026. (c) If alive, give age 38 years

8. AGE:

43

Years

Months

Days

If less than one day

24

hrs.

min.

9. Birthplace

W. VA.

(Town, county, and state)

10. Usual occupation

FARMER

11. Industry or business

FATHER
MOTHER

12. Name

STRAW, MERRITT

13. Birthplace

PA.

14. Maiden name

SNYDER, ELIZABETH

15. Birthplace

PA.

16. Informant

Address

Memorial Hospital
Cumberland, Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

Jan. 26, 1946
(month) (day) (year)

Cemetery or crematory

Salem Cem

Location

Salem, W. Va.

18. Funeral director

Address

Wm. McKen
Augusta, W. Va.

19. Date rec'd by registrar

Jan. 26, 1946

Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH JAN. 24, 1946 19. at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/19/46 19. to 1/24/46 19.and that I last saw him alive on 1/24/46 19.

Immediate cause of death

Uremia

DURATION

Due to

Chronic Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Williams
Address Cumberland Date signed 1/24/46

RECEIVED
JAN 30 1946
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 138 yrs.Hospital, institution, or street address where death occurred:
Marion's HospitalHow long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 184 Grand St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ruth Eileen Strang

3. (b) Social Security Number

214-07-1810

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Richard P. Strang7. Birth date of deceased (mo., day, yr.) May 12 19176. (c) If alive, give age 33 years8. AGE: Years 28 Months 7 Days 17 hrs. min.9. Birthplace Frostburg, Allegheny, Md.
(Town, county, and state)10. Usual occupation Taffel Dept.11. Industry or business Celanese Corp.12. Name Edmund E. Hoffman13. Birthplace Frostburg, Md.14. Maiden name Mary Buchanan15. Birthplace Cumtarsburg, Md.16. Informant Richard P. StrangAddress 184 Grand St. Frostburg, Md.17. Burial Date thereof 1-13-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegheny CemeteryLocation Frostburg, Md.18. Funeral director Joseph G. GattensAddress Frostburg, Md.19. 1-12 19 46 Mrs. Nancy V. Bee

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 46 at 10:55 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 46 to Jan 9 19 46 and that I last saw him alive on Jan 9 19 46Immediate cause of death Tuberculosis (Military)

DURATION

1 mo. (?)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. G. Gattens M.D.Address Frostburg, Md. Date signed 1/14/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1946

BUREAU

RECEIVED
JAN 22 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9420

CERTIFICATE OF DEATH

Reg. Dist. No. 4

00085

1. PLACE OF DEATH:

County AlleganyCity or town Conowingo
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 yearsHospital, institution, or street address where death occurred:
Independence StreetHow long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Conowingo
(If outside city or town limits, write RURAL and give nearest town)Street No. Independence Street

(If rural, give LOCATION)

2.(a) If veteran, name war C

3. (a) FULL NAME

William Swan

3. (b) Social Security Number

None4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary M. Bride Swan6. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) Sept. 28, 18758. AGE: Years 20 Months 23 Days 25 If less than one day

..... hrs. min.

9. Birthplace Conowingo

(Town, county, and state)

10. Usual occupation City Employee11. Industry or business Laundry12. Name John Swan13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Mary M. B. SwanAddress Independence St. Conowingo17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof Jan. 26, 1946

(month) (day) (year)

Cemetery or crematory Hillcrest Burial ParkLocation Conowingo, Md.18. Funeral director W. E. EichhornAddress Conowingo, Md.19. Jan. 20 19 46 Montgomery Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 19 46 at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 23 19 46 to Jan. 23 19 46and that I last saw him alive on Dead on arrival 19 46Immediate cause of death Coronary OcclusionDURATION 3 hrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arthur F. Jones M.D.Address 122 Bedford St.Date signed Jan. 25, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

00086

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:

County AlleghenyCity or town Canascon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County AlleghenyCity or town Canascon
(If outside city or town limits, write RURAL and give nearest town)Street No. Charles Street
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Ellis G. Leardale

3. (b) Social Security Number

4. Sex Female5. Color or race wh6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife.

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) January 19 - 19468. AGE: Years Months Days If less than one day
3 hrs. min.9. Birthplace Canascon
(Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name Ellis G. Leardale13. Birthplace Canascon14. Maiden name May Ellen McConnell15. Birthplace Canascon16. Informant Ellis G. LeardaleAddress Canascon17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 19 1946
(month) (day) (year)Cemetery or crematory Oak HillLocation Canascon18. Funeral director Mr. EckhauerAddress Canascon19. Jan. 19 1946 Dr. E. O. Egle Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19th 1946, at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 18 1946 to Jan 19 1946and that I last saw him alive on Jan 19 1946

Immediate cause of death

Blue baby.

DURATION

3 hours.

Due to.

Due to.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. E. O. Egle

M. D. or other

Address Canascon Date signed 1/19/46

RECEIVED

JAN 19 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 179-20

CERTIFICATE OF DEATH

Reg. Dist. No. 8

00087

1. PLACE OF DEATH:

County Allegany
City or town Lonaconing, Md
If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: ✓

Stay in hospital or inst. (yrs., or mos., or days) ✓

Stay in this community (yrs., or mos., or days) 2 1/2 yrs

3. (a) FULL NAME

Kenneth Russell Timmely

3. (b) Social Security Number

✓

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced child

6 (b) Name of husband or wife ✓

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) May 7th, 1943

8. AGE: Years 2 Months 8 Days 21 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name William Timmely

13. Birthplace Unknown

MOTHER 14. Maiden name Olin Ruth George

15. Birthplace ✓

16. Informant Mrs Olin Bittinger

Address Lonaconing, Md

17. Burial Burial Date thereof Jan 31, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. Jan 31, 1946 Dr. E. Don Egan
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing, "Paris Mt" Ward No. ✓
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ✓
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1946, at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1946, to Jan 28 1946, and that I last saw him alive on Jan 28 1946.

Immediate cause of death

Prisoned from eating rat Paste.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. E. Don Egan

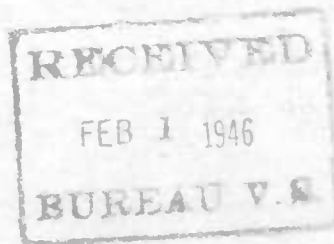
M. D. or other

Address Lonaconing, Md Date signed Jan 29, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98d

00088

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

414 Ind Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 414 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Grace I Swigg

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Clarence E Swigg

7. Birth date of deceased (mo., day, yr.)

Feb 22 1888 6.(c) If alive, give age _____ years8. AGE: Years 57 Months 11 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Old town Ind.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William Foley13. Birthplace Ind.14. Maiden name Mary S. Middleton15. Birthplace Ind.16. Informant H.C. WisegorverAddress 600 St Mary's Ave. Cumberland md17. (Burial, cremation, or removal. Which?) Burial Date thereof 1/28/46
(month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland md.18. Funeral director Louis Stein Inc.Address Cumberland md.19. Jan 28, 1946 Date rec'd by registrar J.B. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 19 46 at 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 9 19 44 to Jan 24 19 46and that I last saw him alive on Jan 24 19 46

Immediate cause of death

ventricular fibrillation?
Stroke - adipsia syndrome.
Myocarditis
Heart block

DURATION

Sudden
5 yrs
"

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

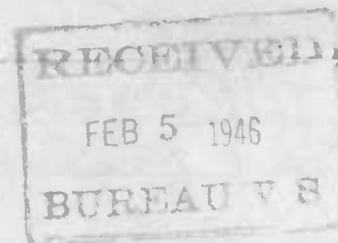
Injured at work?

23. SIGNATURE Wylee R. Everhart M.D. M. D. or otherAddress 36 Greene St Date signed 1/27/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

7306

00089

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 63 Years

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution? 20 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1514 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Luther Valentine

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Belle Valentine6.(c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) September 19 18828. AGE: Years Months Days If less than one day
63 4 7hrs.min.9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)10. Usual occupation Gardner11. Industry or business Truck Farm12. Name Lloyd Valentine13. Birthplace Cumberland, Md.14. Maiden name Anna Luteman15. Birthplace Oldtown, Md.16. Informant Lloyd ValentineAddress 1514, Bedford St, Cumberland, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/46
(month) (day) (year)Cemetery or crematory Zion Memorial CemeteryLocation Cumberland, Md.18. Funeral director William H. LightAddress Cumberland, Md.19. Jan 28, 46 1946 J. O. Franklin
(Date rec'd by registrar) (M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1946, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 25 1946 to January 26 1946
and that I last saw him alive on January 26, 1946

Immediate cause of death

Coronary Atherosclerosis

DURATION

1 1/2 hoursDue to myocardial infarction year 3Due to Chronic Coronary AtherosclerosisOther conditions Chronic Renal

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 7

Means of injury Injured at work?

23. SIGNATURE Blane M. Schneider, M.D.

M. D. or other

Address 41 Green St. Date signed 4/1/46

RECEIVED

FEB 5 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

00090

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
 City or town Lonaconing, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Midland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. L

(If rural, give LOCATION)

2. (a) If veteran, name war. L

3. (a) FULL NAME

Jane F. Wagus

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced WidowedFemale White Widowed6. (b) Name of husband deceased Melvin Wagus

8. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 18978. AGE: Years 48 Months 5 Days 11 If less than one day hrs. min.9. Birthplace Lonaconing, Allegany, Md.
(Town, county, and state)10. Usual occupation House work11. Industry or business Own Home12. Name Robert M. Alfano13. Birthplace Lonaconing, Md.14. Maiden name Agnes B. Brown15. Birthplace Lonaconing, Md.16. Informant Mrs. Thomas PolandAddress Pittsburg, Pa.17. Burial Date thereof Jan 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Franklin, Md.18. Funeral director M. EichhornAddress Lonaconing, Md.19. Jan. 31 1946 D. L. Dan Taylor
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27th 1946 at 10:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 15 1945 to Jan 27 1946and that I last saw her alive on Jan 26 1946

Immediate cause of death

Cardiac failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Henry E. Hodge M. D. or otherAddress Lonaconing, Md. Date signed Jan 31 46

RECEIVED
FEB 2 1946
BUREAU V.E.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Four Week

Hospital, institution, or street address where death occurred:

513 Maryland Ave.How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County SomersetCity or town Meyersdale, Pa.
(If outside city or town limits, write RURAL and give nearest town)Street No. Meyers Ave.
(If rural, give LOCATION)2.(a) If veteran, name war ☒

3.(a) FULL NAME

Joseph G. Weakland

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Marquette O'Donnell7. Birth date of deceased (mo., day, yr.) Mar. 25, 1884
6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

61920

hrs.

min.

9. Birthplace

CONFLUENCE, Pa.
(Town, county, and state)

10. Usual occupation

U.S. Postmaster - Meyersdale, Pa.

11. Industry or business

FATHER
MOTHER

12. Name

Levi W. Weakland

13. Birthplace

Cambria Co. Pa.

14. Maiden name

Sarah E. Thomas

15. Birthplace

Cambria Co. Pa.

16. Informant

John Weakland

Address

Meyers Ave. Meyersdale, Pa.

17.

(Burial, cremation, or removal, Which?)

Date thereof Jan. 18, 1946
(month) (day) (year)

Cemetery or crematory

Phillips & James Cemetery

Location

Meyersdale, Pa.

18. Funeral director

Willoughby & Price

Address

325 Main St. Meyersdale, Pa.

19.

(Date rec'd by registrar)

Jan. 15, 1946 J.P. Kanski, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-46 19____ at 6 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-4-45 to 1-15-46and that I last saw him alive on 1-14-46 19____

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Richard S. Kanski M.D. or other
Address 325 Main St. Meyersdale, Pa. Date signed 1/15/46

RECEIVED
JAN 22 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

Reg. Dist. No. 1.

1. PLACE OF DEATH:

County AlleganyCity or town Little Orleans
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 yrs.Hospital, institution, or street address where death occurred:
—How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Little Orleans (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. R. F. D. 1
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (a) FULL NAME

Columbia Morse Whitfield

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Jeremiah Whitfield

7. Birth date of

deceased (mo., day, yr.)

Aug. 21, 1871

8. AGE:

Years

Months

Days

If less than one day

74411— hrs. — min.

9. Birthplace

Artemas, Bedford Co., Penna.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

OWN HOME

12. Name

Joseph S. Morse

13. Birthplace

Artemas, Bedford Co., Penna.

14. Maiden name

Eliza Kline

15. Birthplace

Artemas, Bedford Co., Penna.

16. Informant

Olney Whitfield

Address

Little Orleans Md.17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Jan. 5, 1946
(month) (day) (year)

Cemetery or crematory

Piney Plains Methodist Church

Location

Piney Plains, Md.

18. Funeral director

Charles R. Bast

Address

Hancock, Md.19. Jan 4

Date rec'd by registrar

19. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 46

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 1, 1946 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 20, 1945 to Jan. 1, 1946and that I last saw her alive on Dec. 31, 1945

Immediate cause of death

Acute Myocarditis

DURATION

11 days

Due to

Due to

Other conditions

Chronic Cystitis2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Watson M.D.

M. D. or other

Address

Little Orleans, Md.

Date signed

1/3/46

RECEIVED
JAN 9 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

00093

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 53 yrs.
 Hospital, institution, or street address where death occurred:
Kelly Springfield Fire Plant
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 14 Market St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Webster Sindley Williams

3. (b) Social Security Number

487-18-81044. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Desire M. Cherry7. Birth date of deceased (mo., day, yr.) June 25, 1888 6. (c) If alive, give age 57 years8. AGE: Years 57 Months 6 Days 7 If less than one day hrs. m/n.9. Birthplace Conaoning, Allegany Co. Md.
(Town, county, and state)10. Usual occupation Real Estate11. Industry or business Kelly Springfield Fire Co.12. Name Henry D. Williams13. Birthplace Scotland14. Maiden name Jane Phillips15. Birthplace Frostburg, Md.16. Informant Mrs. W. L. WilliamsAddress 14 Market St. Cumberland, Md.17. Burial Date thereof Jan 4, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Maryland18. Funeral director John J. HaferAddress Cumberland, Maryland19. Jan. 4 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 19 46 at 10.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death

Coronary Occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(include pregnancy within 3 months of death)

Major findings of operations. ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pinney H. Benson M.D.Address Cumberland, Maryland M. D. or otherDate signed 1-4-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 8 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00094

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

627 Lincoln St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany

City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 627 Lincoln St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Clayton L. Zembower

3. (b) Social Security Number
None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife... Alma Neff Zembower6. (c) If alive, give age... 64 years7. Birth date of deceased (mo., day, yr.) Aug. 12, 1876

8. AGE: Years Months Days If less than one day
69 4 27 hrs. min.

9. Birthplace... Bedford Valley, Penna.
 (Town, county, and state)

10. Usual occupation... Retired Paper Hanger

11. Industry or business

12. Name... A. Wilson Zembower13. Birthplace... Penna.14. Maiden name... Mary J. Rose15. Birthplace... Penna.16. Informant... Mrs. Alma ZembowerAddress... 627 Lincoln St. Cumberland, Md.

17. Burial Date thereof... Jan. 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Zion Memorial Cem.Location... Bedford Road18. Funeral director... Charles L. GeorgeAddress... Cumberland, Md.

19. Jan. 11 19 46 J. P. Hanbler, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan. 9, 19 46 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1st 19 46 to Jan 9 19 46
 and that I last saw him alive on Jan 9 19 46

Immediate cause of death

DURATION

Chronic Myocarditis 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... R. A. Treraskis M.D.

Cumberland, Md M. D. or other
 Address Date signed Jan 10 46

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1946

BUREAU U S